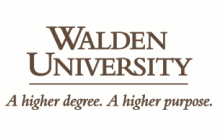

2018

The Novice Licensed Professional Counselor's Perceived Preparedness to Use Self-Disclosure

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Abstract

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by

Nicole Pfaff

MS, Walden University, 2014

BS, Widener University, 2009

Dissertation Submitted in Partial Fulfillment

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Abstract

Self-disclosure is used by feminist, humanistic, client-centered, and a variety of other counselors to build therapeutic alliances with clients. However, little research has been conducted on counselors' perceptions of their preparedness to use self-disclosure. This exploratory multiple-case study used attachment theory as a framework to explore the perceptions of novice licensed professional counselors' preparedness to use self-disclosure. The 12 participants who participated in face-to-face interviews practiced as licensed professional counselors in Delaware, New Jersey, or Pennsylvania. The participants described how they learned, practiced, and used self-disclosure. After analyzing interview data through cycle coding and peer review, themes emerged showing participants' life experiences, clinical practices, education, and supervision as having prepared them to use self-disclosure. Participants perceived they were prepared to use self-disclosure through their educational experience but primarily learned to self-disclose through trial-and-error. Participants reported learning to self-disclose by taking a chance and practicing the self-disclosure skill with clients after receiving their license. Professional counselors, supervisors, and counselor educators who are the gatekeepers for future counselors may use the study's findings to improve understanding of and training in self-disclosure. The findings can be used to enhance the training of how to prepare counselors to use self-disclosure, therefore, minimizing harm to the clients. Learning more about training counselors to use a skill that is of use with or without intent is of significance to the field of mental health counseling.

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Chapter 1: Introduction to the Study

Introduction

Professional counseling is new to the mental health field as compared with psychiatry, psychology, and social work (Scherer & Lau, 2016). Professional counseling gained a separate identity first marked by the formation of the American Counseling Association (ACA) in 1952 (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). All 50 states, the District of Columbia, and Puerto Rico established professional counseling licensure boards subsequent to the ACA's founding (Scherer & Lau, 2016), and licensed professional counselors (LPC) established themselves as practitioners of a unique discipline (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

LPCs have a professional identity distinct from psychiatrists, psychologists, and social workers (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). Unlike counselors, psychiatrists require a doctoral degree to practice and have the capability to issue medication for treatment (Scherer & Lau, 2016). Read (2015) detailed psychiatrists' reliance on using medication to treat mental health concerns. Some psychiatrists use medical treatment without consulting treatment team members who are involved with the client's care such as the client's primary care physician, counselor, or family member(s) (Read, 2015). LPCs are different than psychiatrists given that they are not able to prescribe medication and are not medical professionals (Scherer & Lau, 2016).

LPCs and psychologists work with clients using the same counseling skills and have a purposeful focus on only the client (Scherer & Lau, 2016; Schneider, Pierson, & Bugental, 2014). In psychology and counseling, there are multiple theoretical

perspectives the professional can use to frame their work with clients (Schneider et al., 2014). LPCs and psychologists may use humanistic, behavioral, cognitive, systems, and psychodynamic therapies in their work with clients (Corey, 2012). However, some psychologists emphasize the use their education and knowledge to further the field's understanding of psychology primarily through experimentation or research (Scherer & Lau, 2016).

Social workers provide resources to the client and view the client's entire support system (Scherer &Lau, 2016). Providing direct counseling to clients, their families, and groups is just one aspect of a social worker's responsibility (Thompson, 2015). A social worker will also engage in problem-solving, provide resources, work to link clients to other organizations, and facilitate coordination among treatment team members (Thompson, 2015). Social workers will also offer counsel to family members to assist them in understanding the client (Thompson, 2015). For LPCs, the focus is on the clients only, and on helping them with everyday psychosocial functioning (Scherer & Lau, 2016).

The LPC's primary focus is on building a therapeutic alliance with the client (Scherer & Lau, 2016). LPCs use SD for creating a relationship with the client (Audet, 2011; Berg, Antonsen, & Binder, 2016; Henretty, Currier, Berman, & Levitt, 2014; Ziv-Beiman, 2013). Many counselors have reported that clients see them as humans and not just professionals when counselors use self-disclosure (SD; Audet, 2011). Some clients have reported less power imbalance and more humanization of the counselor when the

counselor uses SD (Audet, 2011; Holmqvist; 2015; Knight, 2014). However, it is unclear how prepared LPCs perceive themselves to be in using SD in-session.

SD can include thoughts, feelings, opinions, biographical or demographical facts about the therapist (Berg et al., 2016; Ruddle & Dilks, 2015; Ziv-Beiman, 2013). Much of the current research has shown that SD is a consequential therapeutic technique (Berg et al., 2016; Henretty et al., 2014). SD can either strengthen the therapeutic alliance or deteriorate the helping relationship (Audet, 2011; Ziv-Beiman, 2013). Critics of SD argue that it is predicated on counselors conducting their therapy in session with a client, exemplary of role reversal (Berg et al., 2016). It is thus imperative that counselors acknowledge the impact of their SD on the client and work to understand the client's reception (Levitt et al., 2016; Pinto-Coelho, Hill, & Kivlighan, 2016).

Researchers have suggested that having an awareness of the impact of SD takes practice and is learned through experience (Berg et al., 2016; Henretty et al., 2014; Knight, 2014; Levitt et al., 2016; Pinto-Coelho et al., 2016; Ziv-Beiman, 2013). However, in my review of the literature, I found few researchers who explored how novice LPCs perceive their preparedness to use SD. The purpose of this study was to explore how novice LPCs perceive their preparedness to use SD.

In this chapter, I address gaps in the current literature included the limited scholarly understanding of how novice LPCs perceive their preparedness to use SD. Next, I discuss the theoretical framework that provided the structure for this study and then outline the nature of the study. Definitions of key terms follow before the chapter

concludes with discussions of my assumptions and the study's scope, delimitations, limitations, and significance.

Problem Statement

While there is a robust body of literature on SD, I found no research on LPCs' perceptions of their preparedness to use SD or on the effectiveness of their experiences learning to self-disclose. Further, I found no research on how counselors perceive themselves as being prepared to use SD, what training they have to use SD, how to seek guidance when SD has a negative impact, or their understanding of how to recognize when the SD blurred boundaries. Educational preparation and training are essential for understanding how to use SD (Audet, 2011; Knight, 2014). The literature review led me to conclude that there is a gap in research regarding LPCs' perceptions of their training for using SD. In this study, I considered possible implications for ongoing supervision or training post-licensure of novice LPCs to address their use of SD.

Purpose of the Study

The purpose of this qualitative exploratory multiple-case study was to understand novice LPCs' perceived preparedness to use SD. The phenomenon of interest focused on the perceptions of novice LPCs preparedness for using the skill of SD and what implications there were for training relating to SD. Novice is defined as an LPC who has more than one year and less than five years of experience. SD is any personal information that an LPC discusses with the client, ranging from thoughts and feelings that arise in-session to personal information about the counselor or therapist (Ruddle & Dilks, 2015).

There are many complexities to using SD, with both positive and negative consequences on the therapeutic relationship (Pinto-Coelho et al., 2016). The current trend in the counseling field is for LPCs to engage in SD with a client (Audet, 2011; Berg et al., 2016; Holmqvist, 2015; Knight, 2014). Many LPCs are using SD as an integrative approach to therapy (Berg et al., 2016; Ziv-Beiman, 2013). SD is also used to strengthen the therapeutic relationship and facilitate growth with the client (Ziv-Beiman, 2013). An LPC's proper use of SD can enhance the therapeutic relationship and build a foundation of trust (Audet, 2011).

However, SD can sometimes set the client's progress back and have harmful impacts on the client's well-being (Henretty et al., 2014; Knight, 2014; Ruddle & Dilks, 2015; Spence, Fox, Golding, Daiches, 2014). Careless use of SD may hinder the therapeutic process or lead to the blurring of boundaries between therapist and client (Audet, 2011; Berg et al., 2016). Levitt et al. (2016), Ruddle and Dilks (2015), and Holmqvist (2015) presented a strong argument for when and why counselors use SD with clients and how it impacts the alliance and outcomes of therapy. Berg et al. (2016) and Ziv-Beiman (2013) explained the use of SD as an integrative intervention. Henretty et al. (2014) and Knight (2014) stated that novice counselors feel uncertain using SD when they are not adequately trained in the technique of self-disclosing.

Research Question

RQ: How do novice licensed professional counselors perceive their preparedness to use self-disclosure?

Theoretical Framework

The goal of this qualitative exploratory multiple-case study was to explore novice LPCs' perceptions of their preparedness to use the SD. Such a method requires the researcher to collect, present, and analyze data (Baxter & Jack, 2008; Yin, 2014). While case studies rely on theory (Baxter & Jack, 2008; Yin, 2014), exploratory case study researchers need to be flexible to allow new theories to emerge as well (Baxter & Jack, 2008; Yin, 2014). I used attachment theory when designing this research (Baxter & Jack, 2008; Yin, 2014). Attachment theory helps explain how relational experiences influence individuals throughout their lives (Schwartz, 2010). Further, attachment theory provides a framework for understanding how past relationships affect individuals' present strategies to deal with triggers. If a therapist is triggered to self-disclose, this may be a result of a relational experience that is reenacting itself in the therapeutic alliance (Bowlby, 1988).

The counselor is the secure base in the therapeutic relationship (Bowlby, 1988; Holmes, 2005). The counselor models healthy relationships for clients (Bowlby, 1988; Holmes, 2005). The therapeutic alliance is crafted by both the counselor and client's perceptions of their roles in the relationship (Bowlby, 1988; Holmes, 2005). However, to maintain boundaries counselors remain aware of their contribution to the relationship and their disclosures (Bowlby, 1988). Counselors' disclosures may or may not be impediments, while client disclosures are facilitators for the counseling process (Bowlby, 1988). Therefore, using attachment theory to understand SD and the therapeutic relationship enables insight into the phenomenon of how LPCs perceive their preparedness to use SD.

Nature of the Study

I used a qualitative, exploratory, multiple-case study design. The fundamentals of qualitative research are to make sense of a phenomenon through the meaning people bring to it using a series of representations such as field notes, interviews, conversations, recordings, and memos to the self (Denzin & Lincoln, 2013). The exploratory multiple-case study approach is a qualitative method that focuses the attention on the situation in which the intervention being evaluated has no clear outcome (Baxter, 2008; Yin, 2014). This design allowed me to explore how LPCs felt about their preparedness to engage in SD). I collected data through face-to-face interviews asking open-ended questions and having a conversation with each participant (Baxter, 2008).

Definition of Key Terms

I used the following definitions throughout this study.

American Counseling Association (ACA) Code of Ethics (2014): An educational, scientific, and professional organization that sets the standards for ethical obligations and guidance in informing the ethical practice of professional counselors (ACA, 2014).

Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards (2016): CACREP is a national organization that is dedicated to promoting excellence in the counseling-related educational programs through accreditation (CACREP, 2016). Educational institutions that demonstrate a quality educational experience through achieving and maintaining the CAREP standards are eligible for accreditation (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

Licensed professional counselor: A licensed professional counselor is an individual who engages in professional talk counseling as a mental health professional with a current license from their state of residency (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

National Board for Certified Counselors (NBCC): An independent, not-for-profit certification agency for those counselors that voluntarily seek professional certification (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

National Counselor Examination for Licensure and Certification (NCE): The certification examination consisting of 200 field related questions (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). The NCE relies on the eight CACREP domains and five empirically validated work behaviors that pertain to competent counseling (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

Novice licensed professional counselor: A practicing licensed professional counselor is defined as a novice when having a limited understanding and skill set to apply interventions and address client problems (Herbert & Caldwell, 2015).

Self-disclosure: A therapeutic intervention in which the mental health professional discloses something personal about him or herself to the client (Berg et al. 2016).

Assumptions

After a comprehensive review of the literature, I made a few assumptions made for this present study. First, I assumed novice LPC knew the meaning of SD. In counselor training, there is a core curriculum to teach students therapeutic techniques and

theoretical orientations; practicum courses present opportunities to apply the learned skills (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). Counselors are made aware of how SD impacts the therapeutic relationship and of SD's impact on the client (Levitt et al., 2016; Spence et al., 2014; Ziv-Beiman, 2013). Therefore, I assumed that novice counselors had some exposure to the concept of SD.

Second, I assumed that counselors were able to accurately recall how they perceive their preparedness to use SD. Counseling has been established as a distinct discipline in the mental health field (Scherer & Lau, 2016). Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). Mental health counseling is a separate professional entity within the mental health field. The educational requirements, training, and state licensing requirements are specific to the profession (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). The pursuit to obtain credentialing as a LPC is a specific professional journey, and I assumed the novice LPC participants would accurately recall the process.

Third, I assumed that the interviewees were open and honest in their dialogue with me. I assumed that participants were willing to help explore this phenomenon. I expected that participants provided truthful accounts of their experiences. I anticipated that interviewees would understand the operational definitions and ask for clarification when needed.

Scope and Delimitations

The purpose of the study was to understand how novice LPCs perceive their preparedness to use SD in urban settings in the eastern United States. My objective was to focus on the counselor's perception based on their professional experience. Through notation of themes in the data, I sought to increase the field's understanding of how novice counselors perceive their preparedness to use. The semi structured interview allowed for counselors to present their perceptions of their experience.

I deliberately delimited the selection of participants to those who had a LPC credential from their respective state. This delimitation narrowed the scope of the study to those professionals who fit the criteria of a LPC. The credentialing for a license to practice as a professional counselor, social worker, psychiatrist or psychologist is predicated on different criteria in each field. Therefore, this study only included those who had obtained the licensure of a professional counselor.

I delimited participant selection to those residing in urban settings of the eastern United States, specifically, the tri-state area which includes Delaware, New Jersey, and Pennsylvania. The locality was within my area of travel by car. I chose this geographic area to allow for in-person interviews. I anticipated that some snowball sampling would result after initial interviews with participants.

Limitations

Generalizing the findings beyond the scope of this study is difficult, as is typical of qualitative research (Maxwell, 2005; Yin, 2014). My aim was not to generalize, but instead to gain insight into a limitedly understood phenomenon. I used a convenience and

purposeful sample that may not reflect all the perceptions of novice LPCs. Due to the small sample size, the findings are not representative of a broader population and are not generalizable. Instead, the focus of this study was on specific cases, and I aimed to achieve analytic generalization with the use of applied theory (see Yin, 2014).

Significance of the Study

In this study, I sought to fill a gap in the literature regarding how novice LPCs perceived their preparedness to use SD. Researchers have described the use of SD in the literature but have not discussed how counselors perceive themselves as being prepared to use SD, what training they have to use SD, how to seek guidance when SD has a negative impact, or how to recognize when the SD blurred boundaries. For these reasons, my study was needed to explore how novice LPCs use their experience to engage in SD in urban settings in the eastern United States.

My findings are significant for training purposes. Findings can be used by educators and supervisors in the mental and behavioral health sciences to gain insight into how novice LPCs perceive their preparedness to self-disclose with clients. It cannot be assumed that counselors are instinctively prepared to use SD. There are criteria for the appropriate use of SD. Disclosing to a client requires effective timing, depends on the status of the therapeutic relationship, and requires attention to how the client will perceive the information shared (Berg et al., 2016; Pinto-Coelho et al., 2016). New counselors lack the expertise and supervisory direction to carefully reflect of their use of SD (Levitt et al., 2016). Researchers have noted the need for an ongoing conversation about counselors' competence when using SD (Audet, 2011).

The findings of my study may be significant for clients' welfare. Findings call attention to the perceived preparedness of novice licensed counselors to use SD in session. Many novice LPCs do not completely realize the effect their disclosure will have on the client (Levitt et al., 2015; Pinto-Coelho et al., 2016). Having counselors who are

confident using SD produces benefits for the client, therapist, and field of professional counseling. Counselors who do not perceive themselves as prepared to engage in SD are seen as unprofessional and inadequate, and inappropriate use of SD can be devastating to the client's mental health journey (Berg et al., 2016; Levitt et al., 2015).

Summary

SD can be either beneficial or injurious to the client and the therapeutic relationship. Counselors use SD to form therapeutic alliances with clients. Once a therapist does self-disclose, it is likely more disclosures will occur (Jourard, 1973). Therefore, I sought to understand novice LPCs perceived preparedness in using the skill. Specifically, I interviewed counselors who had more than 1 year and less than 5 years of practicing experience. Chapter 2 provides a background to the origins of SD use and attachment theory.

Chapter 2: Literature Review

Introduction

Therapeutic use of SD is complex and has the potential for positive and negative impacts on the therapeutic relationship (Pinto-Coelho, Hill, & Kivlighan, 2016; Rogers, 2014). LPCs use SD as an integrative approach to therapy that strengthens the therapeutic relationship and promotes growth with the client (Berg et al., 2016; Ziv-Beiman, 2013). Proper use of SD provides multiple benefits for the therapeutic relationship and the foundation of counselor trust (Audet, 2011).

SD also can cause damaging effects when unwelcomed by the client (Henretty, Currier, Berman, & Levitt, 2014; Knight, 2014; Ruddle & Dilks, 2015; Spence, Fox, Golding, & Daiches, 2014). Careless use of SD hinders the client's process or even blurs boundaries between the therapist and client (Audet, 2011; Berg et al., 2016). Henretty et al. (2014) and Knight (2014) proposed that novice counselors are not certain in their abilities to use SD. Comfort in using the skill is gained through educational training, field training, and professional experience of practicing the skill during client sessions (Audet, 2011; Knight, 2014; Rogers, 2014). However, after a review of the literature, I found a gap regarding how LPCs perceive their preparedness to use SD.

Chapter 2 begins with a review of the search strategy I used to gather literature relevant to the topic. Before delving into each concept, I thoroughly present the theoretical framework. Because this study specifically targets LPCs, I broadly explain the credentialing process for LPCs and then explain the specific process for each of three selected states where I conducted research. The chapter ends with an outline of key concepts related to SD as explored within this study.

Literature Search Strategy

My objective in the literature review was to seek what was currently available to develop an understanding of how, when, and why mental health professionals use the SD. A Google Scholar search for the keyword *self-disclosure* in yielded over 212,000 articles. I modified the date range to exclude articles over 5 years old, which lowered the results to 19,000. I read articles if they could be linked with the Walden University Library to verify they were peer-reviewed. I used Academic Search Complete, PsycARTICLES,

PsycINFO, SocINDEX, and ERIC databases to obtain full articles fitting the criteria of peer-reviewed and published within the last 4 years. I used additional keyword in these database searches including *boundaries, clinical supervision, counseling, disclosure, education, psychotherapists, psychotherapy, psychotherapy techniques, supervision, therapeutic relationship, therapist disclosure, therapist self-disclosure, therapy, and training*. Boolean searches consisted of *use of self*, disclos*, therap* and, counsel**. At the onset, I only saved articles that were published within the last 4 years. Articles older than 4 years provided support for theory and my historical introduction of SD.

Theoretical Framework

Together, John Bowlby and Mary Ainsworth developed attachment theory (Bretherton, 1992). Bowlby sought to link psychoanalysis with the origins of ethology, cybernetics, and evolutionarily theory (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Bowlby proposed that infant sexual fulfillment alone did not explain the child's tie to the mother (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Psychoanalysts at the time initially scoffed at Bowlby's propositions (Bretherton, 1992; Holmes, 2015). However, Ainsworth was intrigued by Bowlby's work (Bretherton, 1992). Her early interest in security theory led Ainsworth to pursue empirical testing of Bowlby's findings (Bretherton, 1992). Bowlby and Ainsworth initiated separate studies and later combined their efforts to further understand the development of parent and child attachment.

John Bowlby graduated from the University of Cambridge in 1928 after studying developmental psychology (Bowlby, 1988; Bretherton, 1992). Post-graduation, Bowlby provided volunteer services at a school for maladjusted children (Bretherton, 1992). The

behaviors and demeanors of these children impacted Bowlby's professional career (Bowlby, 1988; Bretherton, 1992). One child, in particular, was an affectionless teenager who was without a stable mother figure (Bowlby, 1988; Bretherton, 1992). Another child is described as Bowlby's shadow (Bretherton, 1992). Bowlby was fascinated by the implications that there could be another concept for attachment outside of a need for food or feeding by a mother (Bowlby, 1988).

Ronald Hargreaves, a British psychiatrist and the chief of the Mental Health Section of the World Health Organization, sought to appoint a short-term consultant that would report on aspects of the mental health of homeless children (Bowlby, 1988). Bowlby made a pivotal return from the position of an army psychiatrist to child psychiatrist under the appointment of Hargreaves to lead the research project (Bowlby, 1988; Bretherton, 1992). For 6 months, Bowlby worked with James Robertson to gather data that resulted in a report that highlighted maternal deprivation effects on children (Bowlby, 1988). Psychiatrists who embraced traditional psychiatry and psychologists following the learn-theory approach disapproved of Bowlby's lack of explanations for the implications of personality development (Bowlby, 1988). Bowlby refocused his attention on gathering data to support his findings.

Meanwhile, in 1950, Mary Ainsworth (nee Salter) married Leonard Ainsworth and resettled in London (Bretherton, 1992). In looking for employment, Mary Ainsworth was directed to an advertisement for work under John Bowlby's direction (Bowlby, 1988; Bretherton, 1992). Bowlby started a research study in which he examined the effect on personality development of separation from the mother in early childhood (Bowlby,

1988; Bretherton, 1992). Other researchers in this particular project included Mary Boston, Dina Rosenbluth, Rudolph Schaffer, Christopher Heinicke, and Tony Ambrose (Bretherton, 1992). Ainsworth joined the study efforts with Bowlby and James Robertson late in 1950 (Bowlby, 1988; Bretherton, 1992).

Empirical evidence of the time grounded Bowlby's theory that children with healthy mentalities grew from infancy having had a warm and continuous maternal relationship (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Counter to Rene Spitz and Erik Erikson, Bowlby did not agree that the secured relationship developed from oral satisfaction (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Rather, Bowlby focused on another explanation for the secure foundation. Konrad Lorenz's offered a new direction for Bowlby. Lorenz's work with geese provided Bowlby's knowledge of imprinting (Bretherton, 1992). Bowlby then directed his attention to incorporating ethology (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). In 1953, Bowlby introduced his first ethological paper (Bretherton, 1992). Colleagues continued their criticism of Bowlby's new idea (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). However, Ainsworth accepted Bowlby's concepts (Bretherton, 1992).

Ainsworth offered a significant contribution to Bowlby's work. The concept of attachment patterns originated from Ainsworth's classification of relationships between school-aged children and their parents after a prolonged absence from the parents (Bowlby, 1988; Bretherton, 1992). The foundational attachment observations were: positive maternal reception, negative feelings toward the parent, indifference or markedly hostile (Bretherton, 1992). Later, the attachment styles were classified as ambivalent,

avoidant, and secure patterns (Bowlby, 1988; Bretherton, 1992). Ainsworth provided these groupings to identify differences between how children reacted to their parent's return after an extended absence from their parents. Taking note of these between-group differences, Bowlby provided a distinction between the old social learning theory concept of dependency and his new theory of attachment indicating that attachment "performs a natural, healthy function even in adult life" (Bretherton, 1992, pg. 763).

Researcher interest coalesced around Bowlby's publication on mourning that indicated that infantile grief could provide insight into adult grief (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Bowlby determined that without attachment there is no grief (Holmes, 2015). A person that is securely attached can process the loss and not get lost in anger (Holmes, 2015). After these publications, theorists began to agree with Bowlby's ideations of attachment theory. Colin Parkes paired with Bowlby to write a paper on adult grief (Bretherton, 1992). Elizabeth Kubler-Ross, author of *On Death and Dying*, and Cicely Saunders, the founder of the hospice movement also owed credit to Bowlby for their gained insight into human loss processes. Nonetheless, Bowlby still struggled to provide the empirical foundation for attachment theory.

Meanwhile, Mary Ainsworth ventured into an observational study that would validate John Bowlby's ethological views (Bretherton, 1992). She determined to use her understanding of Robertson's data to study 26 families with unweaned babies between the ages of 1 and 24 months (Bowlby, 1988; Bretheron, 1992). Ainsworth sought to examine the attachment that develops between infant and mother (Bowlby, 1988; Bretherton, 1992). Of particular interest, Ainsworth wanted to observe the onset of

maternal preference through the infant's signals and gestures (Bowlby, 1988; Bretherton, 1992). The study, known as the Uganda Project, led to Bowlby and Ainsworth's combined effort to refine attachment theory.

Analysis of the Uganda Project findings yielded a significant correlation between maternal sensitivity and infant attachment (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Mothers who are appropriately responsive to distressed children construct securely attached children (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). Children feel confident in their abilities (Bowlby, 1988; Bretherton, 1992). Whereas, maternal figures who are unable to mediate their children's negative affect promote maladaptive behaviors in their children (Bowlby, 1988; Bretherton, 1992). Negative behaviors continue to ensue as the child works to gain parental attention (Bowlby, 1988; Bretherton, 1992; Holmes, 2015). The third group of mothers with an indifferent demeanor led to an avoidant child who suppresses affect (Bowlby, 1988; Holmes, 2015). These findings led Bowlby to author the *Attachment and Loss* trilogy. The basic tenets of the trilogy were to connect attachment theory based on developments of previously accepted theories with empirical reconciliation.

John Bowlby constructed a new theory of motivation and behavior control that ran counter to Sigmund Freud. Bowlby offered that maintaining attachment is a different form of acquiring homeostasis in which there is a behavioral, not a physiological means to stay within the balance of limits (Bowlby, 1988). The organization consists of models for the self and the attachment figures within the system (Bowlby, 1988). Bowlby offered a cybernetically controlled behavioral system which has instinctive behaviors that can be

continually adjusted based on the environment (Bretherton, 1992). The internal working model can become regulated through the person having made correct outcome predictions. The more adequate the internal system as a working model, the more accurate the predictions (Bretherton, 1992). Obtainment of an efficient internal working model is predicated on two items. First, the interaction patterns of making correct predictions become automatic through routine practice (Bowlby, 1988; Bretherton, 1992). The more interactions in a given context, the more innate the responses will be for the person. Second, the relationship model is stable and not subject to change (Bowlby, 1988; Bretherton, 1992). However, some discrepancies of information received in the relationship are to be expected (Bretherton, 1992). Not all situations will be accurately predicted, but barring no major damage, the balance can be reacquired.

Bowlby applied attachment theory in psychotherapy throughout the last ten years of his life (Bretherton, 1992). All psychoanalytic schools agree that the therapeutic alliance is the prerequisite for psychoanalytic work (Holmes, 2015). Attachment theory can help the counselor understand the client's needs regarding their attachment style (Bowlby, 1988; Holmes, 2005; Schwartz, 2010). The counselor represents the secure attachment base and models healthy patterns for the client (Bowlby, 1988; Holmes, 2005). As the secure base, the counselor is equivalent to the mother role and can offer the safety to explore the client's world (Bowlby, 1988). Therefore, creating a safe space for the adult client to express their thoughts, feelings, and emotions, as well as reworking erroneous models previously learned as a child (Bowlby, 1988). However, there is a cautionary measure for the counselor to be capable of providing the secure base.

The alliance is built by both the client constructing the relationship from their history and from how the counselor acts toward the client (Bowlby, 1988). A counselor must be aware of their contribution to the relationship (Bowlby, 1988). In therapeutic alliances, counselors are offering a secure base, modeling an attachment figure, and proposing a reconstruction of explored memories (Bowlby, 1988). Counter-transference may impede the process (Bowlby, 1988; Holmes, 2005). Therefore, this study used attachment theory to offer an understanding of how past relationships affect present strategies to deal with triggers. If a counselor decides to self-disclose, this disclosure may be a result of a relational experience that is being reenacted in the therapeutic alliance (Bowlby, 1988). LPCs acquire training and experience to learn how to therapeutically work with clients.

Licensed Professional Counselor Credentialing Process

Before an applicant can apply for licensure within their state of residence, they must complete a Master's degree program and gain experience. This section will outline the educational institution standards, describe the state-regulated expectations for experience and provide an overview of the licensing requirements in the states of Delaware (DE), Pennsylvania (PA) and New Jersey (NJ). The administrative code differs from state to state regarding regulations of licensing. Participants of this study actively provide clinical services in these three states. Therefore, each of these state's administrative codes is reviewed.

Supervised Clinical Hours

In additional to graduating from a CACREP program, a LPC applicant must demonstrate completion of supervised clinical hours. The number of supervised hours varies by state. Hours that are obtained before completing the educational program are regarded as hours toward practicum or internship and do not qualify as hours applicable toward licensure. The supervised clinical hours start after graduating from an accredited educational institution.

The supervising counselor has the best opportunity to educate supervisees on the skill of SD (Knight, 2014). However, trainees do not readily discuss their use of SD with their supervisors (Audet, 2011; Knight, 2014; Spence, Fox, Golding, & Daiches, 2014). Therefore, this study examined how LPCs perceive themselves as being prepared to utilize the skill of SD.

Educational Institution Standards

Delaware, Pennsylvania, and New Jersey boards have specified that a LPC applicant must submit an official transcript from an accredited institution of higher education to the board. Accreditation is a specific term applied to educational programs which meet the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or other independent accrediting agency. An institution can demonstrate standards of educational, professional, and experiential quality through acquiring CACREP accreditation (CACREP, 2016). The institution's program must offer student's specific training through qualified faculty and program governance to obtain accreditation (CACREP, 2016). The accreditation alone does not certify that the student

or professional counselor applicant meets the requirements to get a professional license (CACREP, 2016). The applicant must show supporting evidence of qualification to be certified as outlined by each state's administrative code (CACREP, 2016).

State-Specific Licensing Requirements

Applicants prove their capabilities to use counseling skills to their state's licensing board during the credentialing process (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). Standards for acquiring a license to practice as a professional counselor is established by each state's regulatory board (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). Every state within the United States of America has set up a professional board for professional counselors (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). The state's professional board sets the requirements for obtaining an initial license as a professional counselor, as well as the Board will establish criteria to transfer a professional license from another state (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). The regulations can be found in each state's administrative code (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016). The reasoning for outlining these particular states is due to the participation of interviewees from the states of Delaware, Pennsylvania, and New Jersey.

Delaware

The state of Delaware has a two-part process for obtaining the status of a LPC. The applicant must first apply for licensure as an associate counselor of mental health (Delaware Department of State, n.d.). An applicant must complete an application, submit the fee, develop a plan for direct supervision under a currently LPC in the state of DE,

and comply with other standards outlined in the state code (Delaware Department of State, n.d.). Additional requirements include a certification by the National Board for Certified Counselors (NBCC) or other certifying agency, completion of a master's degree program, be free of administrative penalties, not have drug or alcohol related impairments, and shall not have a criminal conviction, either past or pending (Delaware Department of State, n.d.). A licensed associate counselor of mental health (LACMH) can begin counseling clients while receiving supervision from a state licensed mental health counselor (Delaware Department of State, n.d.). Clinical supervision is fully discussed in the following section. The LACMH achieves the LPC status after providing a record of 3200 hours of face-to-face sessions that were conducted under supervision (Delaware Department of State, n.d.).

New Jersey

Licensing requirements for New Jersey are set forth by the Board of Marriage and Family Therapy Examiners Title 13, Chapter 34 of the New Jersey Administrative Code. New Jersey has a two-part process for licensure as a professional counselor (New Jersey Department of State, n.d.). An applicant must submit an application to the board, pay a fee, provide their official transcripts from the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) accredited master's degree program, submit proof that they are free of a criminal history, and provide verification of a passing score on the National Counselor Examination (NCE) (New Jersey Department of State, n.d.). An applicant who fulfills all the requirements of the application is provided a license to practice as an associate counselor (New Jersey Department of State, n.d.). A

total of 4,500 face-to-face sessions completed during supervised hours must be completed for consideration of becoming a LPC in the state of New Jersey (New Jersey Department of State, n.d.).

Pennsylvania

The requirement for licensure in Pennsylvania is a one-step process as outlined by the State Board of Social Work, Marriage and Family Therapists and Professional Counselors. An individual may apply for a license as a professional counseling if they have met the requirements of the accredited educational criteria, provided evidence of a passing score on a board accepted examination, paid the fee, demonstrate good moral character free of felony charges, and show documentation of 3,000 hours of supervised clinical experience (Pennsylvania Department of State, n.d.a). Additional items include presenting fingerprints for criminal and child abuse background checks, attending a child abuse educational webinar, submitting a curriculum vitae and evidencing no pending or ongoing malpractice cases (Pennsylvania Department of State, n.d.b). In Pennsylvania, the supervised Master's level candidate applies directly for licensure after the supervised clinical hours are completed (Pennsylvania Department of State, n.d.b).

Self-Disclosure

SD is any personal information that a counselor discusses with a client (Audet, 2011; Ruddle & Dilks, 2015). The conversation of the therapist's thoughts and feelings toward the client arising in-session is SD (Ruddle & Dilks, 2015; Ziv-Beiman, 2013). Other examples of SD are exchanges about the therapist's credentials, education, insights learned from past clinical experiences with clients, theoretical orientation and therapist's

strategies for handling specific client issues (Berg et al., 2016; Ruddle & Dilks, 2015; Ziv-Beiman, 2013). This study sought to understand how counselors perceived their preparedness to use SD.

Types of Self-Disclosure

SD can be defined as either verbal or non-verbal (Berg et al., 2016). Non-verbal SD includes information that a client can observe, like a counselor's body language, furniture or office location (Berg et al., 2016). Verbal SD is any form of spoken information the counselor shares about themselves (Berg et al., 2016). Further broken into categories, SD is either immediate or non-immediate (Audet, 2011; Berg et al., 2016). A counselor who discusses their thoughts and feelings on the client/therapeutic process is sharing immediate disclosure (Audet, 2011; Berg et al., 2016). Counselor's stating their education or theoretical orientation are examples of immediate disclosure (Audet, 2011; Berg et al., 2016). The non-immediate disclosure is other information that is shared to assist with humanizing the counselor such as their outside experiences, biographical information, or personal stories (Audet, 2011; Berg et al., 2016).

Self-Disclosure Training

There is a lack of evidence to support that classroom training includes a thorough review of therapeutic skills such as SD (Knight, 2014). Also, many counselors continue to report a discomfort with engaging in SD during sessions with clients (Knight, 2014). Teaching therapeutic skills in classroom settings would rely on the educators. However, educators may lack the expertise necessary to teach the skills to student counselors (Knight, 2014). The opportunity to learn the therapeutic skill of SD may not be supported

in the classroom environment as the setting does not offer real-world counseling sessions (Knight, 2014). A classroom setting to practice SD is ideal to explore the manifestations of countertransference that is underlined by attachment (Knight, 2014). Practicum or internship is the first environment that supports the practice of counseling skills in-session with a client (Knight, 2014; Spence et al., 2014). Practicum supervisors work with supervisees to ensure they are managing their emotions and sessions with professionalism (Knight, 2014; Spence et al., 2014). However, counselors reported learning therapeutic skills, specifically SD, from their classroom setting (Knight, 2014). As counselors continued to report learning the skill of SD from the classroom, Knight (2014) sought to explore the phenomenon using a quantitative approach.

Knight (2014) analyzed counselor engagement in SD in conjunction with having revealed their attitudes toward SD. Data was gathered to elicit the counselor's understanding of SD, their comfort of engagement in SD, their perception of SD enhancing the relationship and professional attractiveness through a survey (Knight, 2014). Knight analyzed the data from 455 participants, in which, they completed self-assessment surveys based on Hendricks's Counselor Disclosure Scale. The majority female participants were a sample of graduates and enrolled students in social work. Knight found that supervisees who engaged in a conversation of SD with supervisors were more likely to engage in SD with their clients. However, 71.3% of the participants reported not discussing SD with their field supervisor, and 91% said their education prepared them to engage in SD with clients. Participants that reported they were not

confident about self-disclosing also reported not discussing SD with their supervisor nor feeling prepared by their education on the skill (Knight, 2014).

Supervision Discussing Self-Disclosure

Educational institutions that are credentialed through the Council for Accreditation of Counseling and Related Educational Programs (CACREP) are required to provide students with an opportunity to practice therapeutic skills with clients while being supervised by a currently licensed mental health professional (CACREP, 2016; Spence et al., 2014). Clinical supervision is a training forum for counselors to begin using their therapeutic skills with clients, while under the guidance of a skilled clinician (Spence et al., 2014). The quality of the supervisory relationship is crucial to the counselor's development. Evidence supports that communication is not effective when supervisees feel fearful of supervisor judgment (Spence et al., 2014). A supervisee is inclined to share experiences of countertransference, mistakes, reactions to clients, and other disclosures when the supervisory relationship is supportive (Spence et al., 2014).

Spence et al. conducted a qualitative study that evaluated the perspectives of supervisees and their initiation of discussion on SD with a supervisor. The counselors were not inclined to discuss SD with their supervisor. The counselors reported that they felt reporting use of SD could negatively impact their supervisor's opinion of them in regards to work performance (Spence et al., 2014). Counselors were even less likely to discuss the use of SD with their supervisors when the SD was regarding personal matters. However, the respondents stated they did self-disclose with their clients (Spence et al., 2014).

Spence et al. (2014) evaluated ten clinical psychologists in their qualitative study using a constructivist grounded theoretical lens. All ten clinical psychologists were from the United Kingdom and all engaged in supervision. The counselors reported that they developed preparation to use SD by practice with clients and self-monitoring (Spence et al., 2014). Having an internal mechanism to self-monitor use of disclosure was profound to the participants. However, the precise meaning of *self-monitoring* was not discussed in the study. Instead, Spence et al. found that counselors indicated the use of SD based on personal preferences but did not discuss their use of SD with their supervisors.

Counselor Experience and Self-Disclosure

Increased comfort with the skill of SD has come from practice with clients (Berg et al., 2016). Berg et al. (2016) incorporated Ziv-Bieman's (2013) view of SD as an integrative approach to therapy. The study builds on past studies that recognized the use of counselors' SD. As a qualitative study using a hermeneutic-phenomenological framework, Berg et al. explored ten participants' experiences with SD. In-depth interviews provided the data that was collected. The participant selection is not thoroughly explained in this study. The selection criteria are limited to knowing that the counselors represented a wide variety of theoretical affiliations and had extensive experience. Ten of 12 participants agreed to complete the interviews which lasted approximately 20 minutes. Findings indicated that counselors choose to self-disclose as a means to provoke the client to self-disclose about themselves, to navigate an impasse in the therapeutic process, and to remediate boundary confusion (Berg et al., 2016). Berg et al. found that many counselors reported having learned from their mistakes of

inappropriate SD from earlier years in their career. The conclusion was that SD is more than a technical skill as it is learned through wisdom and reflectivity (Berg et al., 2016).

Holmqvist (2015) also explored the experience of using SD among psychotherapists in Sweden. Until recently, Swedish psychotherapists were reluctant to engage in SD as they related to the original Freudian concept of being a mirror to clients. Through the research, Holmqvist strived to understand the reason therapist use SD and explore therapist training with the skill. Holmqvist utilized the Counselor Disclosure Scale with 167 psychotherapists that ranged from a theoretical orientation of psychoanalytic, psychodynamic, CBT, systemic family therapy, and other orientations. There were 73 participants that had up to five years of experience with the others having more experience, up to 26 years or longer (Holmqvist, 2015).

This study was congruent with others in providing that therapist training was related to the use of SD. Holmqvist found that younger counselors self-disclosed more about their training and relationships than older counselors in-session with clients. The findings indicated more experienced counselors engaged in greater personal and training related SD than younger, less experienced counselors (Holmqvist, 2015).

Novice counselors reported feeling less prepared to use SD, whereas experienced counselors are more willing to engage in SD (Holmqvist, 2015). Therefore, this study attempts to gain a better understanding of how novice professional counselors perceive themselves as being prepared to utilize the skill of SD.

Use of Self-Disclosure

Counselor use of SD during sessions with clients has been debated by multiple theoretical orientations (Audet, 2011; Ziv-Beiman, 2013). Classical psychoanalysis regards SD as off-limits since the psychoanalyst is to remain anonymous to the client (Ruddle & Dilks, 2015; Ziv-Beiman 2013). However, this claim to the neutrality of psychoanalysts may be misunderstood as Freud was prone to SD in-session with his clients (Lynn & Valliant, 1998). A shift of perspectives on SD comes from intersubjective and relational schools of thought where the counselor is encouraged to SD (Pinto-Coelho et al., 2016; Ziv-Beiman, 2013).

Counselors that identify as being relational validate the use of SD as a means to assist clients with relational boundaries by regulating emotional reactions (Audet, 2011; Ziv-Beiman, 2013). Humanistic counselors take a different approach. Counselors that have a humanistic orientation use SD as a way to appear more realistic and vulnerable (Audet, 2011; Ziv-Beiman, 2013). Humanistic counselors believe that if they present as imperfect, they can create a sense of equality between the counselor and client which leads to a genuine relationship (Jourard, 1958). A genuine therapist and client relationship allow for change to occur which promotes healing (Jourard, 1958). Similar to humanistic counselors, cognitive behavioral counselors use SD as a method to normalize the counselor to the client (Audet, 2011). Normalizing of the counselor allows for clients to learn a new perspective of looking at a situation and a new way to react to that event because the client sees the counselor as comparable to themselves (Audet, 2011; Ziv-Beiman, 2013). Feminism is another theoretical perspective which endorses SD (Audet,

2011; Ziv-Beiman, 2013). The purpose of SD for a feminist counselor is to neutralize the power between the client and therapist (Audet, 2011; Ziv-Beiman, 2013).

Ziv-Beiman (2013) examined the use of SD as a facilitator of the therapeutic alliance. Ziv-Beiman (2013) considered SD an integrative approach to counseling. The researcher sought to understand SD's impact on the therapeutic outcome. The proposal was that SD strengthens the counselor and client relationship allowing for client healing. The close relationship facilitates growth and supplements other therapeutic skills (Ziv-Beiman, 2013).

The study utilized a multiple-case study methodology and a theoretical framework of inquiry in which the use of prior theory and research were evaluated. The multiple-case study was a qualitative data collection method that reported on one single case using an abundance of resources to draw the data and in-depth understanding. The subject was a client of the researcher, age 34, female and in her eighth month of treatment (Ziv-Beiman, 2013). There was a substantial time the researcher spent describing the case scenario. Essentially, the researcher shared an example with the client in which there is a similar pursuit of happiness that is not fulfilled despite heroic efforts (Ziv-Beiman, 2013). The case demonstrated how the researcher uses SD to identify faulty patterns in an attempt to facilitate change. In having analyzed the use of the researcher's SD, Ziv-Beiman (2013) did not focus on one aspect, but rather a multitude of understandings for the phenomenon. Not one theory guides the study, but in aligning with the multiple-case study method, an in-depth discussion of theoretical frameworks, theoretical views, and

theoretical orientations were used. Ziv-Beiman (2013) found, as with prior studies, that SD is used by counselors from several theoretical orientations.

However, there are cautions to using SD. According to Pinto-Coelho et al. (2016), it is important for counselors to consider the nature of their disclosure, the therapeutic relationship's strength, the timing and how the client will receive the information before self-disclosing. Also, it is equally necessary to return the focus to the client after the disclosure is presented (Pinto-Coelho et al., 2016). The next section includes a discussion on SD's impact on the client.

Impact of Self-Disclosure

Negative connotations associated with SD are highlighted through Freud who believed that transference and resistance would be harder to process if counselor's disclosed personal information (Henretty et al., 2014). Freud also argued that clients would be more interested in analyzing the counselor than themselves deeming the therapeutic process counter-productive (Henretty et al., 2014). While Freud provided a disagreement with SD use in-session, Freud engaged in SD regularly as understood by Lynn and Vaillant (1998).

Positive implications for SD come from recent studies which indicate the clinical benefits of humanizing the counselor (Ruddle & Dilks, 2015). Counselors that self-disclose are viewed as trustworthy, create a perception of similarity with the client, and can encourage client disclosure (Henretty et al., 2014). SD is a resourceful way to build a therapeutic working alliance (Henretty et al., 2014; Knight, 2014; Ruddle & Dilks, 2015). Berg et al. (2016) gave recognition of SD as a way to mend therapeutic impasses. Berg et

al. (2016) suggested that given the nature of SD, the therapist needs to be secure and stable in relation to attachment theory. The emotional charge of SD is reported as intense, and if it is too intense, the consequences to the relationship and client will be detrimental (Berg et al., 2016).

Henretty et al. (2014) also sought to identify ways in which counselor SD impacts clients. Henretty et al. introduced the opposing views between counselor theoretical orientations that align with counselors as a blank slate philosophy versus counselors that readily disclose. Henretty et al. recorded that over 90% of counselors engage in and support SD. The specific areas of attention were on how the types of disclosure influenced the client's perceptions of the counselor (Henretty et al., 2014).

Henretty et al. gathered the information through a meta-analytic review that utilized PsychINFO and PsycArticles with the terms *disclos*, therap*, and counsel**. Henretty et al. analyzed an initial 184 studies of which 53 met the criteria. The studies that were used must have included two parties of unequal power as with a client and therapist. The analyzed studies must have experimentally measured one or more types of SD with a control situation in which the counselor did not self-disclose. Third, the studies must have examined verbal SD and not non-verbal. Fourth, the included studies were limited to adult participants.

The study results indicated that clients have a more positive perception of their counselor that SD over a counselor that did not include SD (Henretty et al., 2014). However, this study is limited by their use of research studies that, in a review, yielded client favorability of SD from a majority of settings that were not real sessions (Henretty

et al., 2014). However, there were a few studies offered from actual sessions that indicated a higher degree of counselor likability when SD was used (Henretty et al., 2014). Henretty et al.'s findings are useful for providing a basis in which there is client support for counselor SD. Counselor SD can be utilized to enhance the therapeutic relationship (Ruddle & Dilks, 2015).

Levitt, Minami, Greenspan, Puckett, Henretty, Reich and Berman (2016) explored how SD related to client outcomes and the therapy alliance. Levitt et al. (2016) found that SDs that had the purpose of making the therapist appear human were more consistent with better client outcomes. Additionally, client symptomology was lower when the therapist used SD to make themselves appear similar to the client (Levitt et al., 2016). This study was developed in response to the quantitative review that Henretty (2014) published. Henretty found that there was a small positive impact when counselors used SD with clients.

Levitt et al., (2016) sought to further explore the beneficial components of SD. The naturalistic study evaluated 52 therapeutic relationships. The researchers included participants that completed the first session and final session questionnaires, as well as allowed for the taping of either the third or fourth counseling session (Levitt et al., 2016). The study also utilized four measures: *The Client Working Alliance Inventory*, *The Interpersonal Relationship Subscale*, *Symptom Checklist-5*, and *Beck Depression Inventory for Primary Care* (Levitt et al., 2016). As with prior research, the findings indicated that lower clinical symptoms were present when the therapist self-disclosed (Levitt et al., 2016). Also, the client was more willing to return to therapy when the

counselor used SD (Levitt et al., 2016). Due to the known impact of SD, this study furthers the importance of examining the perceived preparedness of novice counselors in using SD.

Summary

This chapter provided a review of each study related concept and the theoretical framework. The theoretical framework was presented by outlining the formation of attachment theory from the early years of John Bowlby's exploration of attachment to the current time compilation of findings that solidify the concept. Next, the Delaware, Pennsylvania, and New Jersey state regulations for obtaining licensure as a professional counselor was provided. The reasoning for outlining these particular states is due to the participation of interviewees from the states of Delaware, Pennsylvania, and New Jersey. Lastly, there is a complete review of concepts related to SD. Chapter 3 will change the focus from the study's background to the methodology. This study uses an exploratory multiple-case study design that allows for in-depth exploration. It is anticipated that there is more than one perception and therefore, interviewing multiple participants will yield themes that lend to understanding of the phenomenon.

Chapter 3: Research Method

Introduction

Chapter 3 is an overview of the research design I used to understand how LPCs perceive their preparedness to use SD in urban settings in the Eastern United States. In this chapter, I focus on the rationale for the design as well as my role in the study. I discuss the study's methodology, including sampling strategy, procedures to identify participants, and instrumentation. Another section of this chapter addresses the data collection and analysis plans. I also discuss concerns regarding trustworthiness and give attention to credibility, transferability, dependability, confirmability, and potential ethical issues.

Research Design and Rationale

In this exploratory multiple-case study, I sought to explore the perceptions of novice LPCs regarding their preparedness to use SD. Therefore, I used a qualitative, exploratory, multiple-case study approach was to explore the phenomenon in which the outcome is not confined to one explanation (Baxter & Jack, 2008; Yin, 2014). There are multiple responses LPCs can provide regarding their perceived preparedness to use SD. The purpose of this study was to understand how novice LPCs perceive their preparedness to use SD to increase the field's understanding and focus on implications for training.

In case studies, researchers place emphasis on theory (Baxter & Jack, 2008; Yin, 2014). For this study, I used Bowlby's (1988) attachment theory. Attachment theory helps to explain how relational experiences influence individuals throughout their lives

(Schwartz, 2010). The theory helps to establish how past relationships will affect the individual's present strategy to deal with triggers. A therapist may respond to a trigger by self-disclosing, and this may be a result of a relational experience presenting in the therapeutic alliance (Bowlby, 1988). However, the exploratory multiple-case study design allows flexibility for new theories to emerge (Baxter & Jack, 2008). There is not only one possible factor the impacts the phenomenon (Baxter & Jack, 2008). Counselors use disclosure for a multitude of reasons, and this research design allowed for exploration of all the possible explanations.

Role of the Researcher

As the interviewer, I served as the data-collection instrument (see Miles, Huberman, & Saldana, 201 4). The collected data is only as good as the skills of the researcher. Therefore, the researcher-as-instrument must have a familiar understanding of the phenomenon being studied (Miles et al., 2014). As a LPC, I have undergone training, educational studies, and field supervision that familiarized me with the concept of SD. Field experience has given me an in-depth understanding of the complexities surrounding the use of SD in-session. However, I did not have a personal or professional relationship with the LPC participants before I interviewed them for this study.

The researcher-as-instrument must have the capacity to gather information from the interviewee while simultaneously observing and vigilantly taking note of detail (Miles et al., 2014). To accomplish the goal of scrupulous data collection, I took field notes, audio recorded the interviews, and transcribed the audio recordings. It was

important to remain non-judgmental, observational, and balanced when engaging with the interviewees (see Miles et al., 2014; Morrow, 2005).

Researchers understand that their subjectivity impacts the data gathered from interviews (Morrow, 2005). In qualitative research, it is common for researchers to make their assumptions and biases explicit to self and others (Morrow, 2005; Rennie, 2004). The reader is able to follow the emergence of data findings through the researcher's collective journaling. I journaled throughout the dissertation process. Journaling allowed for insight and self-reflection along the journey. The journal was a source to review for evaluation of my values, beliefs, and biases through reflexivity. Another strategy I used to maintain objectivity was debriefing with a peer. Debriefing with a peer provides opportunity for reflection (Morrow, 2005). Having the ability to reflect with a peer minimizes researcher bias (Morrow, 2005).

Two peers reviewed the data with me. One peer had over 25 years of experience as both a LPC and as a mental health counseling educator. This peer helped to outline the themes of the data as she identified topics that repeatedly occurred. This peer helped to identify one finding of interest, in which there were significant differences between how a counselor perceived they were prepared to use SD and how they learned to use the skill. Another area of interest to this peer was the question regarding any educational training concerning SD. Most participants responded that their educational experience with SD came primarily from internship and supervision. Two interviewees could describe a time of learning SD in the educational setting, one in an ethics course and another in a cultural awareness course.

The second peer has over 6 years of experience as a LPC, has a private practice, and provides supervision to student counselors. Initially, I had planned to talk with one peer, but after having focused heavily on the educational component, I deemed it necessary to get more feedback from another source. This peer underscored the importance participants placed on having mindfulness to use SD. This peer evaluated the number of responses that indicated the need to have self-awareness and how that ability factored into the participants capacity to use SD.

Methodology

In this qualitative study, I used an exploratory multiple-case study design that concentrated attention on the situation in which the phenomenon of evaluation did not have a clear outcome (Baxter, 2008; Yin, 2014). There is not enough known about how LPCs perceive their preparedness to use SD. I expected that LPCs may provide a wide array of responses that could not be predicted. This exploratory case study provided a detailed picture of the complex situation of SD. I used several forms of qualitative data collection to allow for a deep and rich understanding of the perceptions of LPCs relating to the phenomenon of interest. The fundamentals of qualitative research are to make sense of a phenomenon through the meaning people bring to it using a series of representations such as field notes, interviews, conversations, recordings, and memos to the self (Denzin & Lincoln, 2013). Using the case study approach enabled me to gather insights from various participants. In case studies, participant responses can be diverse and even contradictory. My findings on how LPCs perceive their preparedness to use SD contribute to the body of knowledge on counselors' understandings of SD.

Participants

All of the participants had completed their educational and field experience requirements at a master's level for the degree of clinical mental health counseling. Also, the participants had graduated from educational institutions that had CACREP accreditation as this required for professional counselors who want to obtain licensure by the state. The participants held active licenses as professional counselors in their respective state of practice: Delaware, New Jersey, or Pennsylvania. Some additional criteria for participating were having at least 1 but less than 5 years of post-graduate experience practicing as a LPC.

Sampling strategy. I use a purposive, homogenous sampling strategy to recruit only novice LPC who had graduated from a CACREP institution with a degree in clinical mental health counseling. All of the participants had less than 5 years of experience practicing as an LPC in either Delaware, New Jersey, or Pennsylvania. A homogenous sample allows for focus on people with similar demographics and characteristics (Miles et al., 2014). I targeted LPCs with comparable educational experiences and professional backgrounds.

Sample size. The intended sample size was approximately 12 interviewees or cases. Each individual interviewed is one unit of analysis or case (Baxter, 2008; Yin, 2014). Small sample sizes are typical of qualitative research, and they allow the researcher to gather rich data via in-depth interviews (Marshall, 1996; Miles et al., 2014; Yin, 2014). There are unlimited and an undetermined number of responses when seeking to understand how LPCs perceive their preparedness to use SD. Having a small sample

size allowed for thorough exploration of the phenomenon and an in-depth analysis (see Yin, 2014). I developed 15 questions that directed the participants to explore their perceptions of learning to engage in the therapeutic use of SD. My goal for the semi-structured interviews was to reach data saturation while making sense of the phenomenon through the meanings participants assigned to it. If data saturation had not been met with the initial 12 participants, I would have invited additional novice LPCs to participate in the study.

As opposed to quantitative studies, the purpose of a qualitative study is to thoroughly understand a phenomenon through exploration (Marshall, 1996). Thus, there is not a clear number of participants required for any given study (Marshall, 1996). Data saturation is achieved when the same themes or explanations are repeatedly given by each case. Once new themes stop emerging, the need for further exploration also ends (Marshall, 1996).

Recruitment. I initially recruited potential individuals by conducting an internet search of LPCs in Pennsylvania, Delaware, and New Jersey. I emailed the identified LPCs an invitation to participate. In the event there was only a phone number, I called the number, identified myself as a doctoral student, and asked if it would be okay for me to send an invitation to participate to their email (see Appendix A). Respondents had the option to contact me through email or phone. The respondents then received an email invitation from me to participate in the study. In the email I introduced myself, provided a brief background of the study, stated the perceived time commitment, and provided my contact information for further questions. I recruited additional participants through

snowball sampling in which one original participant provided contact information for two additional participants

Instrumentation. At the time of this study, there were no published instruments that would gather the data unique to an LPC's perception of being prepared to utilize the skill of SD. Therefore, I created a semi-structured interview (see Appendix B). The instrument began with a narrative that provided a background of the study and then included questions to facilitate dialogue. I used probing and open-ended questions. The open-ended questions were developed under the guidance of this study's content expert assuring the questions were directly related to the phenomenon. Peer counselors who are experienced in the field and could offer their professional knowledge also reviewed the questions for efficacy. The panel of peers included three LPCs that had at least 25 years of experience as a licensed practicing counselor. Each peer was a colleague that I had networked with during the obtainment of my licensure, and they agreed to review the interview questions. The panel of peer counselors assured that the questions were directly related to the phenomenon, clearly indicated that therapeutic skill of SD is specifically being explored, and the questions did not incorporate researcher bias. The interviewing tool was not field tested as the panel of peers scrutinized the tool before use in the interviews.

Probing questions are those that entice the interviewee to think deeply about the response to the question (Lieb & Goodlad, 2005; Spencer 2003). It is characteristic of a probing question to be general, allow for multiple responses, is open-ended, and empowers the responder to provide their expertise (Lieb & Goodlad, 2005). The

interview questions for this study were developed according to the standards of a probing question. Answers are not readily available and so using probing questions allows for the researcher to explore the phenomenon.

Validity threats of interviews include researcher bias, response biases, inaccuracies of participant recall, and reflexivity in which the interviewee says what they feel the researcher wants to hear (Yin, 2014). As a trained, LPC, I may have some researcher bias as to how an LPC has learned to use the skill of SD. Also, the researcher holds a preconception that LPCs have learned about SD at some time in their training based on a review of the literature. In collecting data, the researcher was open to recognizing that LPCs may not have a recalled learning experience of SD use. Bias can be controlled but not eradicated (Miles et al., 2014; Yin, 2014). To help control the bias, I ensured that the interview questions were framed to be open-ended eliciting responses from respondents without guiding their line of thinking. A panel of experts read the questions and gave their opinion of whether or not the questions were leading to a particular response. If the questions contained bias, per the panel of experts, the questions were reworded with the expert's assistance to remove bias. The reflective journaling described earlier also served to alleviate researcher bias.

Using the narrative of the semi-structured interview, I explained that this study is exploratory to gain the participant's perceptions of this phenomenon of SD. The purpose of the narrative explanation is to lower the likelihood of response bias. The participants were encouraged to speak openly and freely about their experiences. Respondents were

assured that their responses were not going to be judged so they could speak as to their experience without scrutiny.

Data Collection and Analysis

Data was collected from participants who provided their perceptions of the phenomenon. Semi-structured interview questions, found in Appendix C, were used to collect the data from the individuals. Participants were asked a series of questions that lead to a conversational style interview about their perceptions of using SD (SD). Individuals were asked to discuss their use of SD, their understanding of SD, how they determined when to SD, how they perceive being prepared to use SD, how they learned to SD, if they have educational or field training to use SD, and asked to describe their conversations of SD during their supervisory experience. The data collection was an in-depth interview with the narratives supplied by the participants in this case study approach (Miles et al., 2014; Yin, 2014). Throughout the interview, the researcher assured clarity of the participant's statements. Each interview was audio recorded and transcribed into Microsoft Word documents. After the interviews were transcribed, the researcher member checked with each interviewee. The member-checking ensured the credibility of the information. Participants received the transcripts through email and had the option to either email or call the researcher to make edits.

An additional data set of field notes were also collected. Field notes include a variety of information about direct observations, informal or formal narratives, and other nonverbal material (Yin, 2014). The field notes were a record of ideas, trends, patterns, or concepts that emerged during the in-between time of interviews, or during the data

analysis process (Yin, 2014). After completing the interview, I set aside time to immediately document my thoughts for individual reflection. I wrote down my first impressions, initial ideations of the interview, and feelings in a hardcover paper journal. I utilized jottings when an idea presented during the interview. Jottings are individual ideas that are fleeting and emergent but can enhance insight during data analysis (Miles et al., 2014). Jottings may arise during the interview, in-between interviews, at random brainstorming sessions or during data analysis (Miles et al., 2014). It is important not to dismiss jottings or journaling as they aid in taking the study to a deeper level (Miles et al., 2014). The field notes assisted in tracking changes that support necessary revisions to the interview questions.

Analysis of the data comprised of creating categories, identifying relationships, and concepts that emerged from the participant's responses (Miles et al., 2014; Yin, 2014). To minimize the content of the manuscripts for coding purposes, filler words such as *hmm, um,* and *oh* were removed. Coding is an active process of making sense of the preliminary analysis to start recognizing themes, and concepts that emerge (Rubin & Rubin, 2012). As the researcher, I reviewed the manuscripts and read through for the first cycle of coding. The first cycle of coding was In Vivo which is a manual process by the researcher to capture the interviewee's precise wording (Miles et al., 2014). In Vivo coding, not to be confused with NVivo a computer-assisted qualitative data analysis software (CADQAS) program, is done by the researcher recognizing phrases that are specific to the professional culture (Miles et al., 2014). For example, it is probable that the term *supervision* or *orientation* may be stated throughout the interview provided the

context of the profession. During In Vivo coding, I ascertained the interviewee's definition for key words and created a category based on their meaning of the word. The same process was done for other statements that were striking or appeared relevant to the mental health field. Categories were the second part of versus coding wherein the first portion codes were listed, in the second part, the codes were grouped into categories (Saldana, 2016). The coding labels underwent a comparing and contrasting process where the researcher looked at the list several times until categories appear that further sorted the data (Saldana, 2016).

The second cycle of coding was pattern coding to condense down the volume of data into smaller units, allow for ongoing researcher analysis, and provide the groundwork for comparison across cases (Miles et al., 2014). In pattern coding, there is an objective to summarize four areas of themes, explanations, relationships among people, and theoretical constructs (Miles et al., 2014). I looked for parts that brought the data together. The data sorting process and identification of common themes led to narrowing in on an understanding of the phenomenon, as such, the subsequent interview questions had the potential to be adjusted (Miles et al., 2014). The sorting process was mapped out by hand and then in a CADQAS program for visual clarity. A peer LPC reviewed the mapped charts and engaged in a discussion of their observations with me. In explaining the data findings, I used narrative description. The In Vivo component of First Cycle coding aided in creating the narrative as I incorporated verbatim interviewee statements. The narratives also assisted with trustworthiness as it allowed the reader the opportunity to draw their conclusion of the same data (Shenton, 2004).

Trustworthiness

Qualitative research must be able to stand up to scrutiny just as quantitative studies. Strategies for dependability include giving a sound argument for the use of methods (Ravitch & Carl, 2016; Shenton, 2004). The detailing of methodology and provision of instruments will enable a future researcher to replicate the same study with the same or similar tools and generate similar results (Ravitch & Carl, 2016; Shenton, 2004). The qualitative foundation is built upon an understanding that the study is very much subjective to the researcher as the world is subjective (Ravitch & Carl, 2016; Shenton, 2004). Reflective noting and journaling become the audit trail to provide an opportunity to follow the researcher's coding and theming process (Ravitch & Carl, 2016; Shenton, 2004).

Ethical Procedures

The data collection interview, invitation to participate, and participant consent forms received approval by Walden University's Institutional Review Board (IRB) before being utilized by the researcher. Walden University's approval number for this study was 1108-17-0329684. Also, all ethical procedures set forth by Walden University's IRB were followed to ensure the protection of the participants and their rights. Participation in the study was voluntary, and the participants could choose to withdraw from the study at any time without retaliation or penalty. There was not any monetary or tangible incentive for completing the interview.

As this study relied on interviewee responses, the interviews were audio recorded with the consent of the participant. Participants were provided with information about the

nature of the study, risks, and benefits of completing the interview, and afforded the opportunity to ask questions. Participants were cautioned not to disclose names of other persons or organizations throughout the interview as to protect the identity of themselves and others. However, limited information about the demographics of their educational institution was discussed.

The interview schedules were coded using a fictitious name that the interviewee creates. Interviewees provided self-reports and past recollection in response to the interview questions. It is uncertain how accurate the data from the interviewee was as it relied on their perceptions and memory recall. Data was stored at the researcher's home office in a locked filing cabinet. Participants were informed, and the researcher will shred/delete the original data after five years.

Summary

This chapter discussed the study's research design. There was a discussion about the rationale for the research design and the researcher's role in the study. One section addressed the study's methodology that included sample strategy, identifying participants and instrumentation. The chapter included a review of the data analysis plan. Another section included considerations for trustworthiness, giving focus to credibility, transferability, dependability, and confirmability. The chapter ended with a final focus on potential ethical issues.

Chapter 4: Results

Introduction

My aim in this study was to understand novice LPCs' perceived preparedness for engaging in SD in their professional practice. At the time of this study, there were few studies of novice LPCs' perceived preparedness for using SD.

I investigated the perceptions of novice LPCs through an exploratory multiple-case study approach. The qualitative method of choice focused my attention on the phenomenon (Baxter, 2008; Yin, 2014). This design allowed for me to explore how LPCs felt regarding their preparedness to engage in SD. I collected data through face-to-face interviews asking open-ended questions and having conversations with the participants (see Baxter, 2008).

Research Question

RQ: How do novice licensed professional counselors perceive their preparedness to use SD?

In this chapter, I present the participant demographics and characteristics. I then review my data collection practices including the number of participants, the location of interviews, the data collection instrument, and any variations in data collection. Next, I discuss data processing and analysis and review the transcriptions and coding method that ensued in the emerging themes. The section ends with a discussion of the evidence of trustworthiness, followed by the results.

Participant Recruitment

To locate participants, I entered the key term *licensed professional counselor* and the respective state of either Delaware, New Jersey, or Pennsylvania, into the search bar of the Google search engine. The search resulted in website links to *Psychology Today*, the respective state's licensing board, Indeed, and some miscellaneous advertisements. I did not use Indeed because it is a website that advertises career openings. I selected *Psychology Today* listings to locate LPCs. Participants were first identified in Pennsylvania using my zip code and an expanded radius of 20 miles. The inquiry led to 236 results for LPC. I followed the same process for the states of Delaware and New Jersey. The search for Delaware participants led to 137 profiles; a search of New Jersey LPCs resulted in a list of 119 profiles.

I reviewed each profile for years of experience and verification of LPC status. The *Psychology Today* profile provided the LPC's license number. Having the license number, I verified each participant's license by looking up their number on the respective state's board of licensing website. Participants were excluded in the case that the license number was not correct, years of practice did not match the criteria, or the licensed was not-active. The years of experience criteria excluded most potential participants. Most professionals that advertised on the *Psychology Today* website had more than 5 years of experience in the field. Approximately 90% of the listings were excluded based on this first criteria. Also, individuals were removed from the potential pool of applicants if their license was expired or invalid. The narrowed list included 5 candidates from Delaware, 26 from Pennsylvania, and 6 from New Jersey.

I contacted 38 potential participants by phone. If they answered the phone, I provided a brief review of the study and asked them to provide their email address for an invitation to participate in the study. If they did not answer the phone, I left a voicemail message that provided a brief review of the study and asked for a return call in which they were asked to provide an email address for an invitation to participate in the study. Eight individuals declined to participate, 16 did not respond, and 14 individuals agreed to set-up an interview. Of the 14 who agreed to interviews, two did not show up at the arranged time, and one was excluded after the audio recorder did not capture the entire interview. I recruited two additional participants through snowball sampling.

All 12 participants provided assurance that they had graduated from an accredited college with a Master's degree in mental health counseling. The participants acknowledged that their school has received accreditation from the CACREP. CACREP is a national organization dedicated to promoting excellence in counseling-related educational programs through accreditation (CACREP, 2016). Educational institutions that demonstrate a quality educational experience through achieving and maintaining the CAREP standards are eligible for accreditation (Coker & Dixon-Saxon, 2013; Scherer & Lau, 2016).

Participants were licensed by their state board to practice as mental health counselors. A total of 8 participants practiced and held an active license in Pennsylvania, 2 held a license in Delaware, and 2 had a license from New Jersey. The average length of experience was 2 years and 9 months. None of the participants had attended the same

college or university. There were 12 different CACREP-accredited colleges represented in the data.

The interviews took place in a variety of locations. Two interviews occurred in the waiting room of the counselor's office, seven took place in the counselor's office, and three took place in a community meeting room. Each interview lasted approximately 20 minutes, with the exception of one in which the participant declined to provide significant insight. One male and 15 females responded to the invitation. However, two of the females did not show up for their interviews.

Demographics

I analyzed data from interviews with 12 participants. The demographic breakdown is shown in Table 1.

Table 1

Interviewee Demographics

Interview number	Sex	Years of experience	Licensure State
1	Female	1 year	Pennsylvania
2	Female	1 year 3 months	Pennsylvania
3	Female	1 year 11 months	Pennsylvania
4	Female	1 year 7 months	Pennsylvania
5	Female	1 year 3 months	Pennsylvania
6	Female	2 years 4 months	Pennsylvania
7	Female	4 years 4 months	New Jersey
8	Female	2 years 10 months	Pennsylvania
9	Female	5 years	New Jersey
10	Male	4 years 4 months	Delaware
11	Female	4 years 11 months	Delaware
12	Female	2 years 4 months	Pennsylvania

Participant 1 (P1)

P1 was a female with 1 year of experience practicing as a LPC in the state of Pennsylvania. Her experience was in private practice working alongside two other therapists. The three LPCs shared two offices on the second floor of a two-story building. The office had one waiting room with chairs for adults and children, magazine, toys, puzzles and a sound machine. I conducted the interview in the waiting room because the two offices were in use by colleagues.

Participant 2 (P2)

P2 was a female with 1 year and 3 months of experience practicing as a LPC the state of Pennsylvania. Her experience was in private practice as the sole practitioner. P2's office was located on the second floor of a publicly accessed building in Hershey. P2's office did not have a waiting room, and she reported that often people would mistakenly walk-in on active therapy sessions. P2 had a sound machine in her office of practice. The office had two chairs with fabric covering, two wooden framed chairs, two blankets, multiple pillows, a bookshelf with educational books and a desk off to the back corner. The office had no pictures, certificates, or diplomas on the walls.

Participant 3 (P3)

P3 was a female with 1 year and 11 months of experience practicing as a LPC in the state of Pennsylvania. Her experience was in public practice with a variety of counselors, therapists, psychiatrists, family counselors, and administrators. P3 had an office with a wooden framed chair, a metal desk in the corner, and a dog bed on the floor.

P3's dog was heard barking from behind another door nearby. P3 indicated the dog was for therapy use, but not specifically the counselor's therapy dog.

Participant 4 (P4)

P4 was a female with 1 year and 7 months of experience practicing as a LPC in the state of Pennsylvania. She had experience in both a public organization that offered multiple services as a mobile therapist, as an outpatient therapist and behavioral specialists, and as a school counselor. P4 reported that her office space was shared at the public organization and she had a pre-decorated office in the school setting. The interview was conducted at a meeting place, and therefore I made no notes about the décor or location of the meeting room space.

Participant 5 (P5)

P5 was a female with 1 year and 3 months of experience practicing as a LPC in the state of Pennsylvania. P5 was one of four therapists at the privately-owned organization. P5 stated that she worked with children from 4 years of age up to adolescents. P5 stated that some of her clients were adults. However, the office was decorated to mainly accommodate younger clients with colorful wall-art, pillows, cushions, toys, craft supplies, and games. P5 had three photos of landscapes above a window, and four certificates, including her University diploma, hung above her desk.

Participant 6 (P6)

P6 was a female with 2 years and 4 months of experience practicing as a LPC in the state of Pennsylvania. P6 is one of a multitude of professionals serving in an out-patient clinic. I conducted the interview in an office setting, but not at the office in which

P6 provides services. P6 stated that she has a photo of her dog in the office, but does not have her certificates or diploma on display. P6 did not go into great detail about the office.

Participant 7 (P7)

P7 was a female with 4 years and 4 months of experience practicing as a LPC in the state of New Jersey. P7 privately practiced and was the sole owner of her organization. P7 reported she practiced as a Christian counselor. The office was set-up with neutral tone colors such as peach, shades of brown, and blue. The wall décor contained landscape photographs. P7's certificates sat on a wall shelf adjacent the wall art. There were three fabric covered armchairs with throw pillows in the office.

Participant 8 (P8)

P8 was a female with 2 years and 10 months of experience practicing in a drug and alcohol facility. P8 was a LPC in the state of Pennsylvania. P8 said that she worked at an in-patient drug and alcohol facility that was publicly owned and operated. P8 stated that she was a teacher at two local universities. The interview was conducted at the university in which she was employed and not at her office of practice. P8 reported not having photos of her family, husband, or any other such décor that provided personal information to the client.

Participant 9 (P9)

P9 was a female with 5 years of experience practicing in a private practice setting with a clientele of all ages with all types of areas of concern. P9 was a LPC in the state of New Jersey. P9 said she worked in private practice, but still had a clinical mentor she met

with by phone or in-person for consultation. The interview was conducted in her office. She had many photos on her two side tables, and there were inspirational sayings on placards hung on the walls. There were various figurines throughout the office. P9 did not have her graduate certificate on the wall. The office had a home-like feel with a bit of clutter and had a feel of a friendly personality.

Participant 10 (P10)

P10 was a male with 4 years and 4 months of experience practicing in private practice who shared an office space in a building of offices for various professions. Each office in the building was occupied by one therapist. P10 was a LPC in the state of Delaware. P10 was the only male that responded to participate in the study. The interview was conducted in the therapist's minimally decorated office. There was one chair that was self-proclaimed as his chair and one chair for the client. The therapist chair was a four-legged wooden chair with leather covering while the other chair was a four-legged wooden chair with fabric covering. The therapist did not have a desk in the office, but there was a coffee table with one box of tissues.

Participant 11 (P11)

P11 was a female with 4 years and 11 months of experience in faith-based mental health counseling. She had a private practice within a brick and mortar building complex and did not share her office space. P11 requested to interview in her waiting room as she would need to stop as soon as her next client arrived for a counseling session. P11 reported that a quarter of her clientele population were traumatized children. The waiting room had a brown wicker basket filled with stuffed animals, faith books on a bookshelf,

and two two-person couch-like seats. On top of the bookshelf were prayer cards, a dish of hard candy, and photos of people.

Participant 12 (P12)

P12 was a female with 2 years and 4 months of experience in the clinical mental health field. She worked in a setting with several other therapists that each had their specific office and shared three waiting lounges. The therapist disclosed that the building was initially constructed in 1850 and had its original brick and exposed rafter beams for visual appeal. The interview was conducted in the therapist's office which was contemporarily decorated with one grey fabric covered couch, one grey fabric covered chair and one desk with chair. The wall had three of the therapist's certificates on the wall, but no other personal items. There was a small wooden bookshelf. The book titles were hidden by the therapist's chair. There were some blue canvas pictures that stood out against the brick walls.

Data Collection

Each participant was interviewed one time. The duration of the interviews ranged from 8 to 20 minutes. Participants answered 15 questions that were reviewed by professionals in the field of professional counseling (see Appendix B). Each of the 12 interviews were audio recorded at the participant's location of choice and then transcribed into a Word document within hours of ending the conversation. While typing out the dialogue, the audio recorder was paused and restarted as not to miss words. After the transcription was done, the audio recording was played again while simultaneously

reviewing the transcriptions to correct for mistakes. Words such as *um*, *ah*, *hmm*, and *like* were removed as necessary for ease of reading and clarity.

The manuscripts were then sent by email to the interviewee for their review. Each manuscript that was sent by email required a password to open the document. Members agreed to a password at the onset of the initial interview. Member checking was used so the interviewee could ascertain the accuracy of the recording, provide clarifying statements and make one last consent to the use of their input. All of the participants approved the manuscripts and authorized use of the data for this study.
No follow-up interviews were performed, and no changes were made to the manuscripts.

There were no variations in data collection from the plan presented to the institutional review board. However, on one occasion there were an additional two clarifying questions asked of the participant. P10 stated he went to school 40 years ago for his mental health counseling degree. During the interview, he was asked to re-verify how many years of experience he had practicing post-graduation. P10 indicated that he had four years and four months, making him eligible to participate. There were two unusual circumstances encountered during the interviews. First, nine participants scheduled the interview in-between their scheduled counseling sessions. The scheduling of the interview in-between clients caused rushed responses. Second, only one male responded to the invitation to participate in the study.

Data Analysis

Each transcript was printed in its entirety, resulting in twelve packets. Another set of documents contained just the responses to one question from all the interviewees.

Therefore, there were two sets of documents. One set of twelve documents had each interview separated. The other set of fifteen documents was a compilation of answers to question one, then question two, and so on consecutively. The transcripts were read and reread in their entirety. In vivo coding was used for the first cycle of coding. In Vivo coding uses short phrases from the participant's own words and language as a code (Miles, Huberman, & Saldana, 2014).

Striking statements and statements that pertained to answering the question were highlighted as the transcripts were read. A spreadsheet was created to capture the In Vivo coding and then the associated pattern coding. The first cycle of In Vivo coding assisted with developing themes that then led to making inferences about the overall data. The themes were reviewed for categorization. For example, the codes *trial and error* as well as *practice* were categorized as *practice*. During the first cycle I also journaled personal thoughts and made jottings of potential patterns.

Specific Codes, Categories, and Themes

Perceived preparedness. Participants were asked to discuss their perceived preparedness to use the skill of verbal SD with clients. The responses were listed on an Excel sheet and 5 categories emerged: Life Experience, Practice, Education, Supervision, and Not Prepared. The process for creating categories started by reading and rereading the transcripts. Next, the phrase that captured the overall point of the interviewee's response was written into an Excel sheet. Then, after reading the responses, initial one or two-word categories were assigned. I reviewed these in vivo phrases and categories with

two different peers to determine whether they would assign the same meaning. Lastly, similar categories were combined to make a theme. Examples of each category are:

Life Experience

- “before I even got into this field and using my life”
- “developed it on my own experiences”
- “always been non-officially the clinician”
- “life and relationships”
- “I’ve been around, I’ve got wisdom from just years”

Practice

- “just practicing being a counselor”
- “just something I did”
- “experience, you know”

Education

- “Bachelor’s school”
- “grad school”
- “my program did a really good job”
- “and my education”

Supervision

- “talk to my supervisor”
- “watching my supervisor”
- “intern monitoring”
- “supervision”

Not Prepared

- “I am not prepared”

Question eight. Participants were asked to discuss how they perceived that they were prepared to use the skill of non-verbal SD with clients. The responses were listed on an Excel sheet and 4 categories emerged: Life Experience, Practice, Education, and Not Prepared. Examples of each category are:

Life Experience

- “developed it on my own experiences”
- “life, professional career, having children, being a wife and a mother”
- “comes naturally”

Practice

- “learned by trial and error”
- “just something I did”
- “by making some mistakes”
- “learned from experience”

Education

- “really was the program”

Not Prepared

- “I really wasn’t think about disclosing that”
- “I wasn’t prepared for that”
- “no, I wasn’t”

Question nine. Participants were asked to talk about how they have learned to self-disclose with clients. The responses were listed on an Excel sheet and 4 categories emerged: Practice, Education, Supervision, and Not Prepared. Examples of each category are:

Practice

- "just with trial and error"
- "it has been kind of trial and error"
- "I tried self-disclosure"
- "the opportunity to work with clients and see what worked and what didn't"
- "by messing up with it"
- "I learned by doing"
- "they have always depended on me or wisdom"
- "knowing when is my experience going to be beneficial"
- "years of experience building trust"

Education

- "between classroom…"

Supervision

- "process through with supervisors"
- "…and supervisors"
- "really that supervision"

Not Prepared

- "I didn't learn"

Question ten. Participants were asked to talk about any educational training that they may have had relating to SD. The responses were listed on an Excel sheet and 3 categories emerged: Education, Not Prepared by Education and Uncertainty. Examples of each category are:

Education

- "brought up in every course"
- "maybe cultural awareness class"
- "had a great a great ethics teacher"
- "my program did a good job"
- "the program was so intense"
- "grad school kind of prepared me"

Uncertainty

- "don't feel like there was much education training"
- "in graduate school, maybe"
- "there is some mentioned in your courses"
- "I don't remember having an actual class"

Not Prepared by Education

- "did not have educational training"
- "not formally, no"

Question eleven. Participants were asked to talk about any field training they may have had relating to the use of self-disclosure. The responses were listed on an Excel

sheet and 2 categories emerged: Field Training Prepared and Not Prepared by Field Training. Examples of each category are:

Field Training Prepared

- "talk during supervision"
- "I could just watch her"
- "talked about self-disclosure"
- "my supervisor said you have to be prepared"
- "had an amazing clinical mentor"
- "had discussions with the supervisor"
- "internship program really trained me"
- "learned a lot about situations in the field"
- "I expressed to that individual [client]…so I learned"

Not Prepared by Field Training

- "there wasn't any experience"
- "none that I can think of"
- "I don't remember"

Question twelve. Participants were asked to talk about any licensure supervision they may have had relating to the use of self-disclosure. The responses were listed on an Excel sheet and 3 categories emerged: Received Supervision, Limited Talk with Supervisor, and Not Prepared by Supervisor. Examples of each category are:

Received Supervision

- "lots of supervision"

- “they were very cognizant of ethics”
- “my clinical mentor, somebody to talk to or call”
- “I learned a ton of stuff from her”

Limited Talk with Supervisor

- “topic came up once or twice, but not often”
- “if I knocked on my supervisor’s door and ask her”
- “one or two times in the entire year”
- “that wouldn’t of been the topic if I didn’t bring it up”
- “he gave some feedback”

Not Prepared by Supervisor

- “I haven’t had any”
- “there wasn’t any”
- “I can’t remember”
- “I don’t remember”

Question thirteen. Participants were asked to talk about how they were prepared to use self-disclosure. The responses were listed on an Excel sheet and 4 categories emerged: Life Experience, Education, Practice, and Supervision. Examples of each category are:

Life Experience

- “developed of my own experience”
- “just my life”
- “because I am older”

Education

- “I taught an ethics class”
- “from grad school”
- “internship”
- “ethical/professional guidelines and training”

Practice

- “just learning through practice and having the chance”
- “had to do it to prepare”
- “if it helps the client”

Supervision

- “listening to other people use self-disclosure”
- “supervisors should bring up in supervision”

Question fifteen. Participants were asked to talk about what they would tell other counselors about becoming prepared to use self-disclosure. The responses were listed on an Excel sheet and 3 categories emerged: Mindfulness, Practice, and Education. Examples of each category are:

Mindfulness

- “be very careful and cautious”
- “know if the self-disclosure is going to benefit”
- “I would say again, one of the things I like to do is to become mindful. I always to preach to be mindful in session”

- “know yourself, take your own healing journey. The healthier you are the better able to serve our clients”
- “do the evaluation that I just mentioned, which is to try to be aware of the issues and your issues that you are not doing your own work”
- “very much be aware, is the counselor likely to be evaluating themselves”
- “I had a friend of mine who lost their license. They were talking about their issues. My whole point is they didn’t know that [that they were disclosing too much], and you need to be able to know that [know you as the counselor are doing too much self-disclosing] and be cautious”
- “evaluate, ‘is this something that is going to benefit the client to know” rather than ‘would I really like them to know this abut me because then they would like me more’ because that’s not what it [self-disclosure] is for”

Practice

- “learn from each time”
- “practice”
- “trial and error”

Education

- “look for workshops and webinars”
- “have an excellent teacher”
- “understand ethics”

Discrepant Cases

Some respondents indicated that they did not use SD. Question two asks the counselor to discuss their use of SD. P10, P11, and P12 each stated that they rarely ever use self-disclosure, but over the course of the interview, these participants reported situations in which they had used SD.

P10 stated:

> I use it rarely. Extremely rarely. I really don't. That's about it. I really rarely use self-disclosure. I will do it if I am seeing a client who is 70 years old and the client can feel more comfortable, I let them know my age.

P11 stated:

> When a client is suffering with very low self-esteem and feel that problems are quite unique to them. They see it as a never-ending pattern of defeat, when in actuality it is normal everyday life. I will say, 'Well I have been there' and explain if I am speaking, depending on what we are talking about, a very specific incident and how it is resolved. I talked about my experience with it and how it was resolved to show an end-point and gain closure.

P12 stated:

> One more thing, I think I self-disclose more with the teenagers that I work with in order to build rapport. Because I do allow, quote on quote, teenagers to ask me questions. Just random stuff like that I don't mind them knowing, because teenagers need to know a little more in order to feel comfortable. I think that I am

very careful not to try and forge a friendship with clients, even though there are some that I think I could totally be friends with, they don't need to know.

Evidence of Trustworthiness

Following the procedural design, as outlined in chapter three, is a component of ensuring trustworthiness. The procedure for recruiting participants adhered to the process as approved by the institutional review board. An internet search for LPCS in the state of Pennsylvania led to a website link for *Psychology Today*. After clicking on *Psychology Today*, the search for LPCs was refined by geographic area to include a 20-mile radius from the researcher's home. Profiles of LPCs were reviewed to determine years of experience. The potential interviewee was then called and asked if they would like to share their email address for review of an invitation to participate. Interviews were scheduled with participants that called back and agreed to be a part of the study.

The only exception to the process was two participants that were obtained via snowball sampling. One participant stated she would contact her colleagues and have them make contact with the researcher if they were interested. Two participants were acquired by this process, both holding licenses in Pennsylvania. The same procedural process was followed to invite participants from New Jersey and Delaware. Following the procedural process of acquiring interviewees is a part of trustworthiness. Credibility, dependability, and confirmability are also reviewed to establish trustworthiness.

Credibility

Credibility assures that there is truth value (Miles, Huberman, & Saldana, 2014). Data must be context-rich and meaningful (Miles et al., 2014). Therefore, the transcripts

are provided verbatim in the appendix for readers to draw their conclusions and verify that the explanation made sense and was plausible. Credibility was also sustained through the assertion that data collection conveyed the accurate report as intended by the interviewee. Also, narrative reports of the data provided clarity and took the reader through a step-by-step process of understanding the concluded.

Dependability

Dependability accounts for such points as whether the process of the study is consistent, stable over time and across methods (Miles et al., 2014). The research question was clearly established with features of the study designed to be congruent with the question. As the researcher, my role and status within the site was described. My role was of a researcher who shared a similar experience with the participants. The shared experience is inclusive of our educational training and licensure training in the field of mental health counseling. Data were collected from participants at their location of choice. I documented the décor of the surroundings and verified the LPCs years of experience through verbal communication and a public records search.

Data was collected and processed using In Vivo coding, memo taking, and audit trails. The audit trail included all the raw data compiled into two sets of documents. The audit trail also consisted of my reflections before, during and after the data collection and was jotted into a journal. This was to ensure transparency and reduce bias. The data also was transcribed into manuscripts for review of correctness by the participants. Through reading and rereading the transcripts the first cycle coding lead to striking statements

which were highlighted. The statements were isolated and reviewed for categorization. NVivo aided with the presentation of the data.

Confirmability

Confirmability relies on the tenants of objectivity and neutrality (Miles et al., 2014). The interview tool of this study was reviewed by a panel of peers to evaluate for bias. Also, the transcripts were written verbatim to avoid introduction of bias. Transcripts were reviewed by participants. Participants were offered the opportunity to make corrections. No alterations were made by the interviewees, confirming the audio recording was typed verbatim. Journaling also allotted time for reflection on the entire dissertation process from conceptualization to data analysis. Note taking, memos and jottings detailed the process from onset to the end. Using detailed methods and procedures, the reader has a complete representation of the process (Miles et al., 2014). Each step of deductive categorization was presented to provide explicit reasoning of the drawn conclusions.

Results

The purpose of this study was to explore how novice LPCs perceived their preparedness to use SD. Several themes and patterns emerged through the data analysis process. There are eight major interpretations from the findings:

1. Participants did engage in self-disclosure.
2. Participants could define self-disclosure.
3. Most of the participants defined non-verbal self-disclosure as body language.

4. Participants identified life experience, clinical practice, education and supervision as having prepared them to use SD.
5. Participants perceived they have learned how to SD mainly by clinical practice, but with some supervision and life experience.
6. Education prepared half the participants to use SD.
7. Field training prepared nine of the participants to use SD.
8. Supervision during licensure prepared eight of the participants to use SD.

Each of the eight interpretations will be reviewed next. The findings are discussed in the chronological order as listed above. There are tables for each finding that provide a visual of the coding process. Also, there is a figure that shows a visual representation of the data.

Finding 1: Participants Report Engagement in Self-Disclosure

Participants did engage in the use of SD with clients. All of the participants mentioned some use of SD. P2 reported "I use a lot of self-disclosure." P11 and P12 reported minimal use of SD. Table 2 lists the codes, categories, and theme. Figure 1 shows the amount of self-reported SD.

Table 2

Finding 1 Coding, Categorization, and Themes

Code	Category	Theme
“I do use self-disclosure minimally”	Minimal	Uses self-disclosure
“I use a lot of self-disclosure”	Significant	Uses self-disclosure
“I used it today”	Moderate	Uses self-disclosure
“I try to limit my use of self-disclosure”	Minimal	Uses self-disclosure
“I do use some self-disclosure”	Minimal	Uses self-disclosure
“I don’t really share”	Minimal	Uses self-disclosure
“I will self-disclose”	Moderate	Uses self-disclosure
“I actually will use it to help clients sometimes”	Minimal	Uses self-disclosure
“one of the first things I do is share”	Moderate	Uses self-disclosure
“Extremely rarely, I really don’t”	Minimal	Uses self-disclosure
“I had used it in specific instances”	Minimal	Uses self-disclosure
“I rarely use self-disclosure”	Minimal	Uses self-disclosure

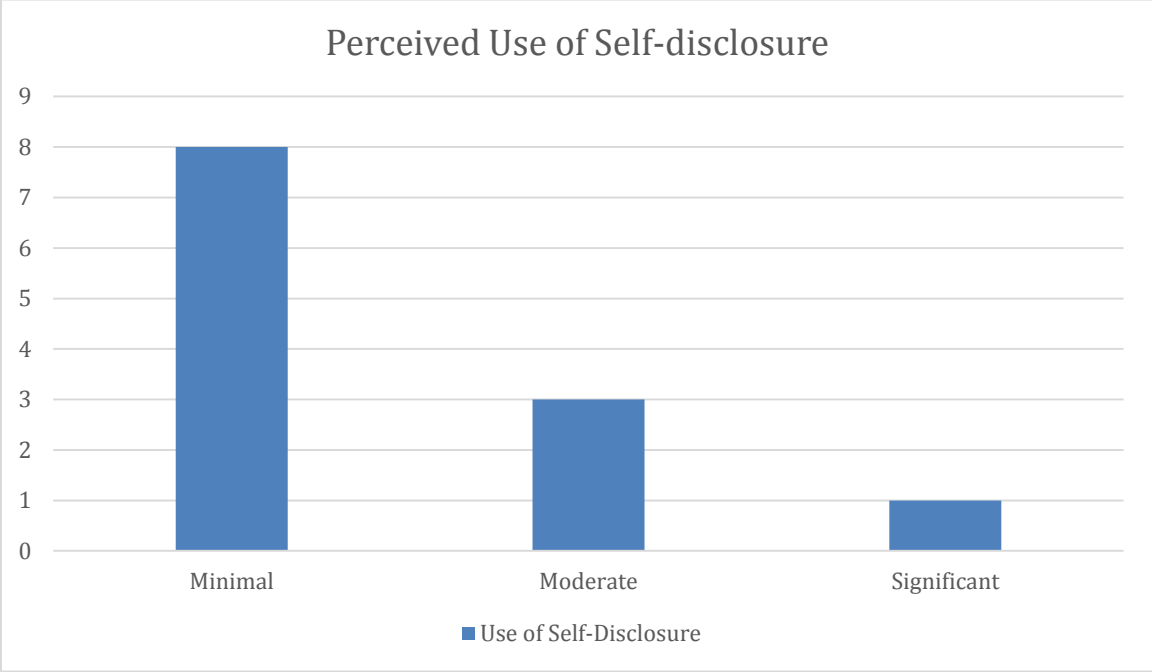

Figure 1. Perceived use of self-disclosure.

Finding 2: Participants Define Self-Disclosure

Participants could define SD. Participants of this study were able to define and give examples of verbal SD. P10 was the exception to which they stated, "I am not sure what you mean." Question three asked participants to define verbal SD. The following are responses to question three:

P1 "sharing something personal with the client"

P2 "sharing verbally my experience"

P3 "saying something that has happened to you"

P4 "saying something to a client that would give them some additional information about who I am"

P5 "something that I say to the client about me and tell them something that is personal"

P6 "I guess just telling clients about some of things that you might use or might be helpful…that you have [used] to [get] through"

P7 "sharing about me, some experience, life experience"

P8 "I share something either about myself or a colleague"

P9 "anything that we do or say… I am actually able to tell my clients that I may have experienced something similar"

P11 "I will sometimes disclose to let them know they [the client] are human and it is normal"

P12 "talking about myself"

Finding 3: Participants Define Non-Verbal Self-Disclosure

Most of the participants defined non-verbal SD as body-language. Eight of the twelve participants defined non-verbal SD as body language. Two participants reported that they could not define non-verbal SD. P7 stated "I don't really understand what that would look like." P10 stated, "I do not have any personal disclosure" and shook her head. P6 identified non-verbal SD as a feeling, "I guess it could be like if I felt uncomfortable." P8 described non-verbal SD as clothing and jewelry that is worn.

Finding 4: Participants Identified How They Were Prepared to Use Self-disclosure

Participants identified Life Experience, Clinical Practice, Education and Supervision as having prepared them to use SD. Interview questions 7, 8, 9 and 13 are worded to have the counselor discuss how they perceived they were prepared to use the skill of SD. Interview question seven is worded to focus on verbal SD, whereas question eight only addressed non-verbal SD. After having an in-depth conversation on perceived preparedness for the use of SD, participants were given one more opportunity to address how they learned to use SD in question thirteen. Table 3 lists the codes, categories, and themes for interview question seven in which interviewees were asked to discuss how they perceived they were prepared to use the skill of verbal SD. The codes for this section and each subsequent section reflect participant's verbatim phrases or keywords. The overall sentence was not captured, but instead just the striking phrases that pertained to the study are included.

Table 3

Finding 4 Coding, Categorization, and Themes - Verbal Self-Disclosure

Code	Category	Theme
"before I even got into this field and using my life"	Life	Life Experience
"just practicing being a counselor"	Practice	Clinical Practice
"Bachelor's school"	School	Education
"developed it on my own experiences"	Experience	Life Experience
"just something I did"	Practice	Clinical Practice
"grad school"	School	Education
"experience you know"	Practice	Clinical Practice
"my program did a really good job"	Program	Education
"talk to my supervisor"	Supervisor/talk	Supervision
"watching my supervisor"	Supervisor/watch	Supervision
"always been non-officially the clinician"	Experience	Life Experience
"intern mentoring"	Mentoring	Supervision
"life and relationships"	Life/relationship	Life Experience
"I am not prepared"	Not	Not Prepared
"I've been around, I've got wisdom from just years"	Wisdom	Life Experience
"supervision"	Supervision	Supervision
"and my education"	Education	Education

Figure 2 shows the emphasis LPCs placed on each category in which they have perceived was the source for how they were prepared to use verbal SD.

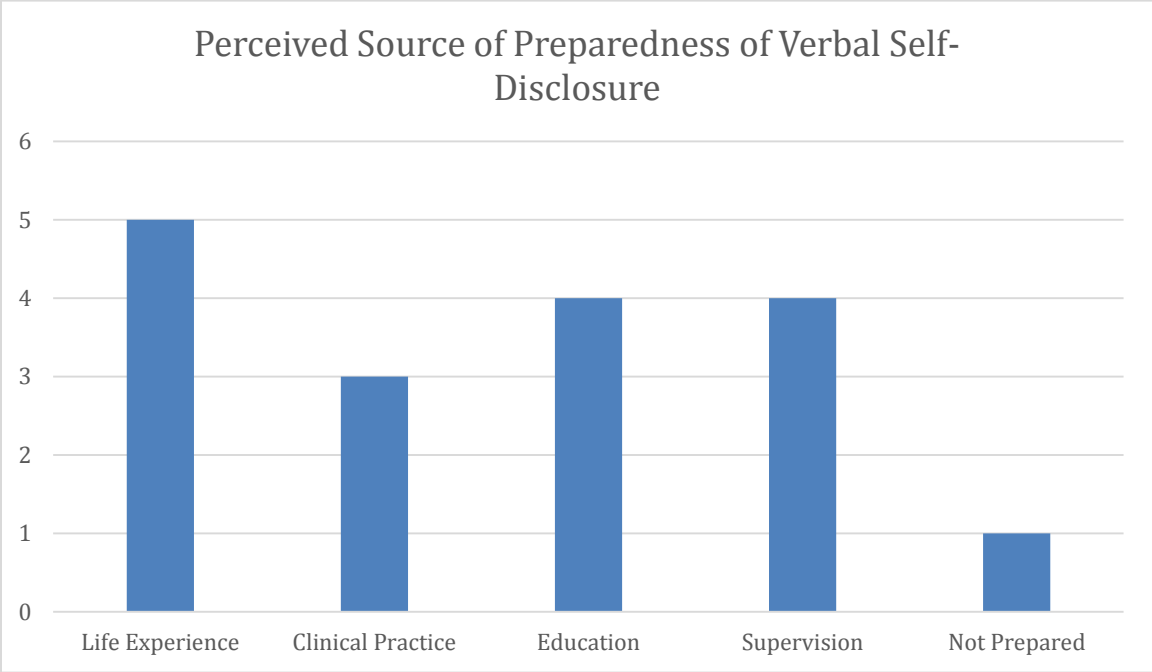

Figure 2. Categories of perceived source of preparedness for verbal self-disclosure.

Table 4 lists the codes, categories and themes for interview question 8 in which interviewees were asked to discuss how they perceived they were prepared to use the skill of non-verbal SD.

Table 4

Finding 4 Coding, Categorization, and Themes -Non-Verbal Self-Disclosure

Code	Category	Theme
"I really wasn't thinking about that"	Not	Not Prepared
"learned by trial and error"	Trial and Error	Clinical Practice
"developed it on my own experiences"	Experience	Life Experience
"just something I did"	Practice	Clinical Practice
"I wasn't prepared"	Not Prepared	Not Prepared
"by making some mistakes"	Mistakes	Clinical Practice
"really was the program"	Program	Education
"life, professional career, having children, being a wife, and a mother'	Experience	Life Experience
"no, I wasn't"	Not	Not Prepared
"comes naturally"	Wisdom	Life Experience
"learned from experience [in trying]"	Trying	Practice

Figure 3 shows the emphasis LPCs placed on each category in which they have perceived they were prepared to use non-verbal SD.

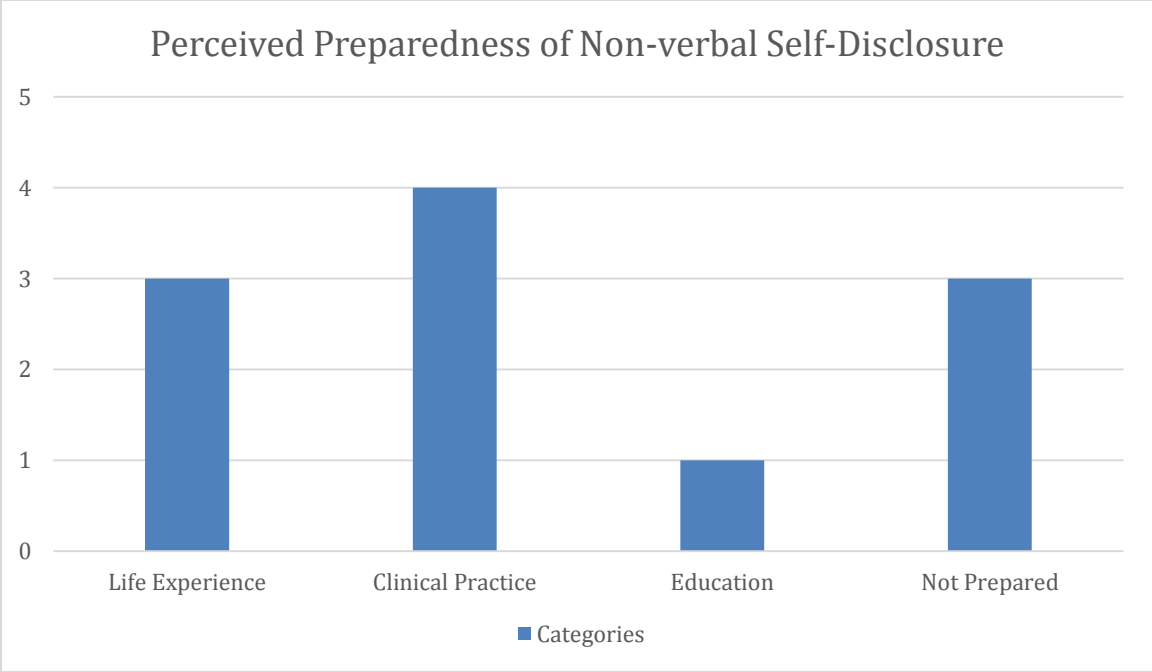

Figure 3. Categories of perceived preparation for non-verbal self-disclosure.

Table 5 lists the codes, categories and themes for interview question thirteen in which interviewees were asked to discuss how they perceived they were prepared to use the skill SD.

Table 5

Finding 4 Coding, Categorization, and Themes - Perceived Preparedness of Self-Disclosure

Code	Category	Theme
"I taught ethics class"	Class	Education
"developed on my own experience"	Experience	Life Experience
"just learning through practice and having the chance"	Practice	Clinical Practice
"from grad school"	School	Education
"internship"	Internship	Education
"listening to other people use self-disclosure"	Supervision/group	Supervision
"had to do it to prepare"	Do it	Clinical Practice
"supervisors should bring up in supervision"	Supervision	Supervision
"just my life"	Life	Life Experience
"because I am older"	Age	Life Experience
"if it helps the client"	Practice	Clinical Practice
"ethical/professional guidelines training"	Training	Education

Figure 4 shows how the perception of being prepared to use SD after an in-depth conversation on learning to SD through education, field training/internship, and licensed supervision training.

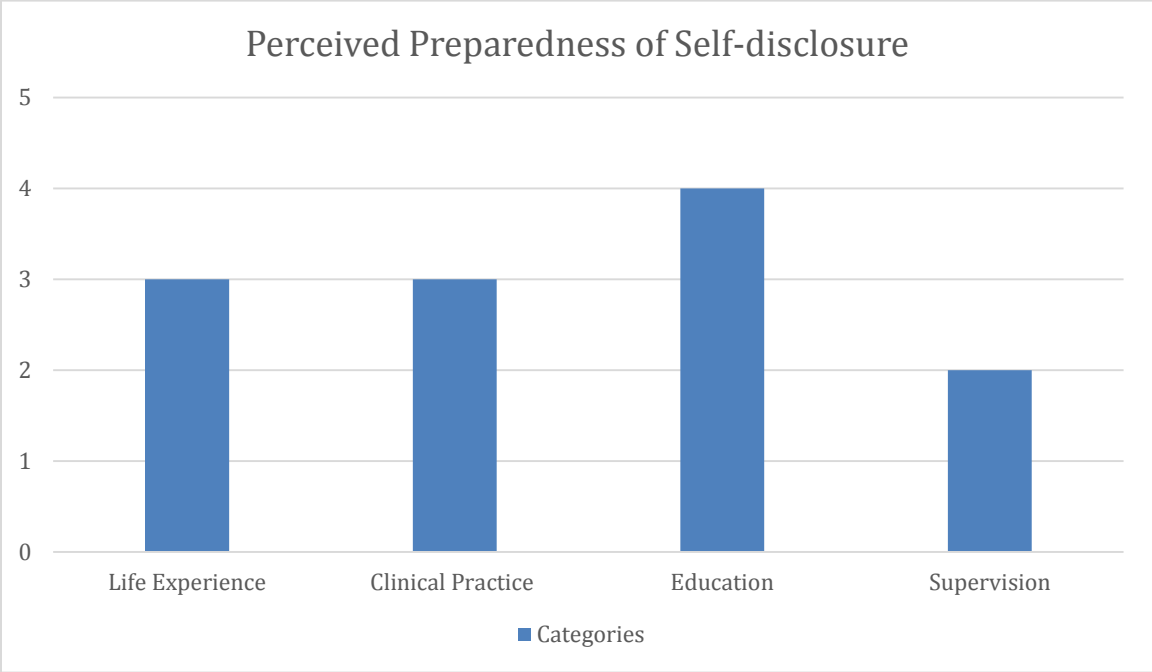

Figure 4. Perception of having been prepared to self-disclose.

Finding 5: Participants Identified How They Have Learned to Self-Disclose

Participants perceived they have learned how to SD mainly by practice, but with some supervision and life experience. Table 6 lists the codes, categories and themes for interview question 9 in which interviewees were asked to discuss how they perceived they learned to use the skill of SD with clients.

Table 6

Finding 5 Coding, Categorization, and Themes

Code	Category	Theme
"process through with supervisors"	Supervisor/talk	Supervision
"just with trial and error"	Trial and Error	Clinical Practice
"it has been kind of trial and error"	Trial and Error	Clinical Practice
"I tried self-disclosure"	Practice	Clinical Practice
"the opportunity to work with clients and see what worked and what didn't"	Trial and Error	Clinical Practice
'by messing up with it"	Trial and Error	Clinical Practice
"I learned by doing"	Practice	Clinical Practice
"really that supervision"	Supervision	Supervision
"they have always depended on me for wisdom"	Experience	Life Experience
"I didn't learn"	Not Prepared	Not Prepared
"years of experience building trust"	Practice	Clinical Practice
"questioning and being aware of what I am doing"	Questioning	Clinical Practice

Figure 5 shows the emphasis LPCs placed on each category in which they have perceived they learned to use SD. It is noteworthy that the novice LPCs in this study have identified *clinical practice* as the primary factor in which they are learned to SD, but perceived to have been prepared by *life experience*, *clinical practice*, *education* and admittedly *not prepared* at all.

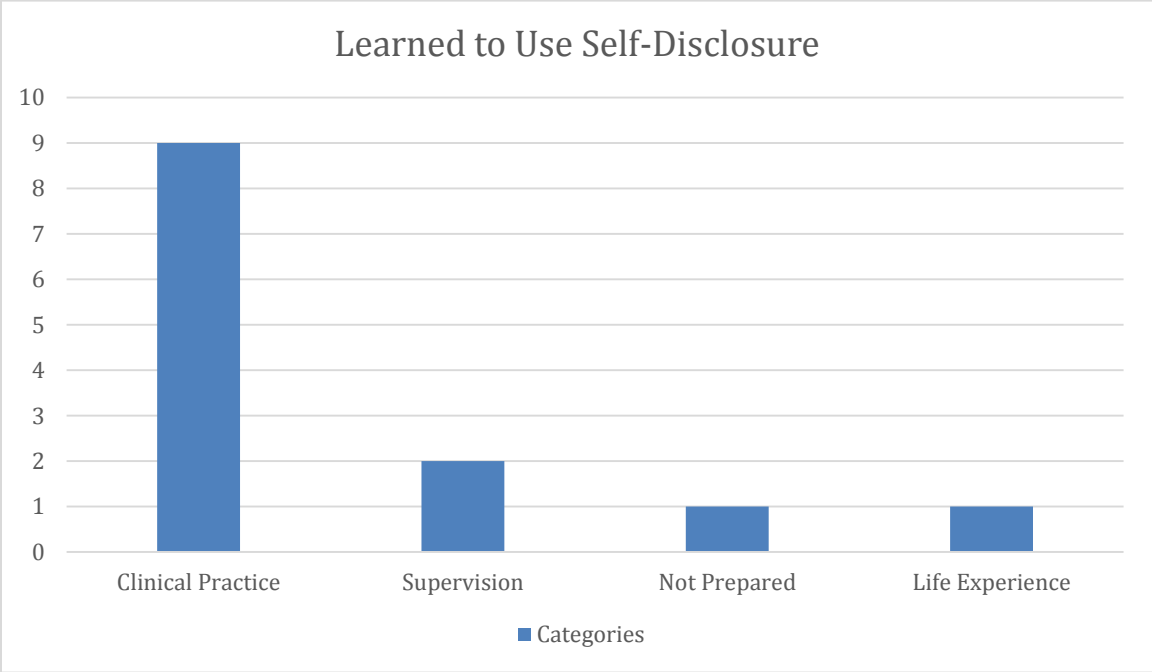

Figure 5. Categories of perceived learning of self-disclosure.

Finding 6: Education Prepared Some Participants to Use Self-Disclosure

Education prepared half the participants to use SD. Participants were asked to talk about any educational training that they have had relating to SD. Half of the interviewees identified some educational training. Table 7 lists the codes, categories, and themes for interview question ten which asked participants to discuss any educational training that they have had related to SD.

Table 7

Finding 6 Coding, Categorization, and Themes

Code	Category	Theme
“brought up in every course”	Education/yes	Education Prepared
“learned from your own experiences”	Education/no	Not Prepared
“maybe cultural awareness class”	Education/yes	Education Prepared
“did not have educational training”	Education/no	Not Prepared
“don’t feel like there was much educational training”	Education/no	Not Prepared
“in graduate school, maybe”	Education/uncertain	Not Prepared
“grad school kind of prepared me”	Education/yes	Education Prepared
“had a great ethics teacher”	Education/yes	Education Prepared
“my program did a good job”	Education/yes	Education Prepared
“the program was so intense”	Education/yes	Education Prepared
“not formally, no”	Education/no	Not Prepared
“there is some mentioned in your courses”	Education/uncertain	Not Prepared
“I don’t remember having an actual class”	Education/no	Not Prepared

Figure 6 shows the emphasis LPCs placed on each category in which they can recall that they had educational training relating to SD.

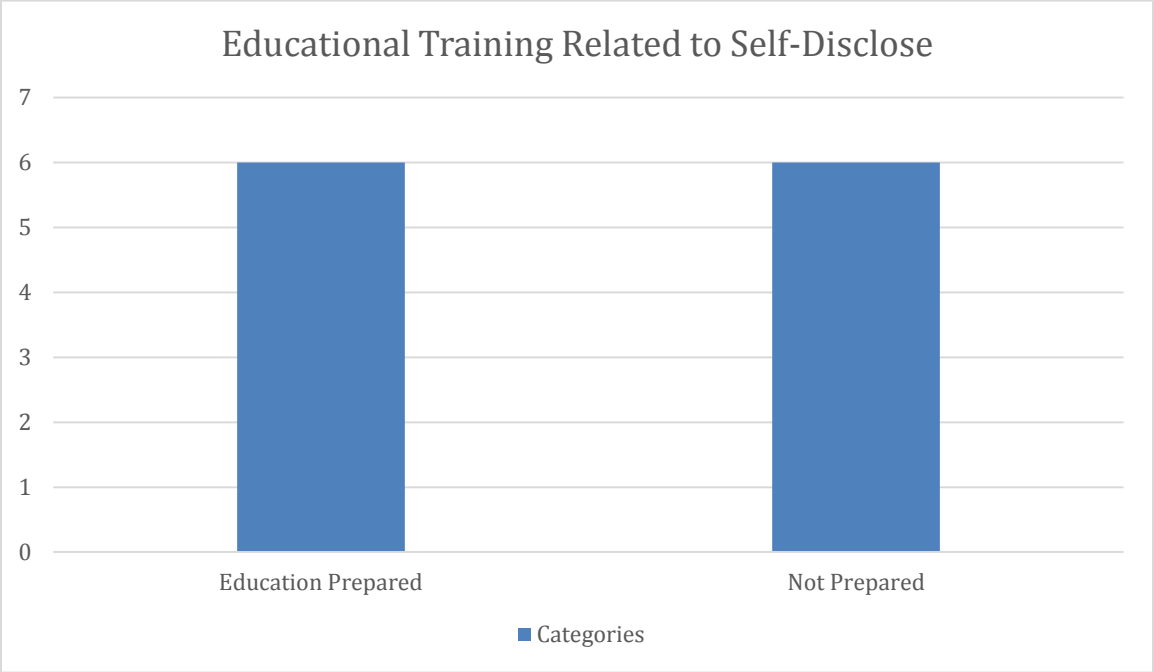

Figure 6. Response to having educational training on self-disclosure.

Finding 7: Field Training Prepared Some Participants to Use Self-Disclosure

Field training prepared nine of the participants to use SD. Nine of the twelve participants reported that they had field training relating to SD prior to graduating from their graduate school. Table 8 lists the codes, categories, and themes for interview question eleven.

Table 8

Finding 7 Coding, Categorization, and Themes

Code	Category	Theme
"talk during supervision"	Supervisor/talk	Field Training Prepared
"I could just watch her [mentor]"	Supervisor/watch	Field Training Prepared
"talked about self-disclosure, I think"	Supervisor/talk	Field Training Prepared
"there wasn't any experience"	Not Prepared	Not Prepared
"none that I can think of"	Not Prepared	Not Prepared
"internship program really trained me"	Trained	Field Training Prepared
"learned a lot about situations in the field"	Learned Field	Field Training Prepared
"my supervisor said you have to be prepared"	Supervisor/talk	Field Training Prepared
"had an amazing clinical mentor"	Supervisor	Field Training Prepared
"had discussions with the supervisor"	Supervisor/talk	Field Training Prepared
"I expressed to that individual… so I learned"	Learned	Field Training Prepared
"I don't remember"	Not Prepared	Not Prepared

Figure 7 shows the number of participants that reported they had field training related to SD.

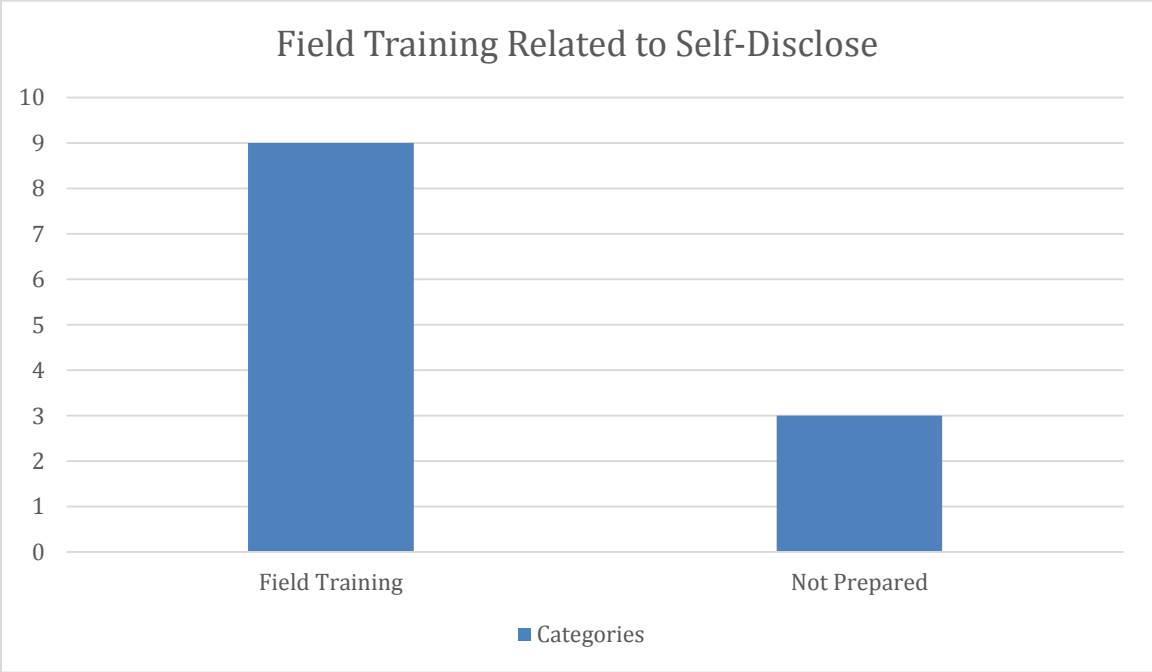

Figure 7. Response to having field training related to self-disclosure.

Finding 8: Supervision Prepared Some Participants to Use Self-Disclosure

Supervision during licensure prepared eight of the participants to use SD. Eight of the twelve participants reported that they had supervision during their acquisition of licensure relating to SD. Table 9 lists the codes, categories, and themes for interview question twelve. It is important to note that in four of the nine cases when there was licensure supervision, the subject was trainee initiated or minimal.

Table 9

Finding 8 Coding, Categorization, and Themes

Code	Category	Theme
“lot’s of supervision”	Supervision/yes	Licensure Supervision
“they were very cognizant of the ethics”	Supervision/yes	Licensure Supervision
“I haven’t had any”	Supervision/no	Not Prepared
“topic came up once or twice, not often”	Supervision/yes	Licensure Supervision
“there wasn’t any”	Supervision/no	Not Prepared
“knock on my supervisor’s door and ask her”	Supervision/yes	Licensure Supervision
“I can’t remember”	Supervision/no	Not Prepared
“one or two times in the entire year”	Supervision/yes	Licensure Supervision
“that wouldn’t of been the topic if I didn’t bring it up”	Supervision/yes	Licensure Supervision
“my clinical mentor, somebody to talk to or call”	Supervision/yes	Licensure Supervision
“I don’t remember”	Supervision/no	Not Prepared
“he gave some feedback”	Supervision/yes	Licensure Supervision
“I learned a ton of stuff from her”	Supervision/yes	Licensure Supervision

Figure 8 shows the number of participants that reported they had licensure supervision related to SD.

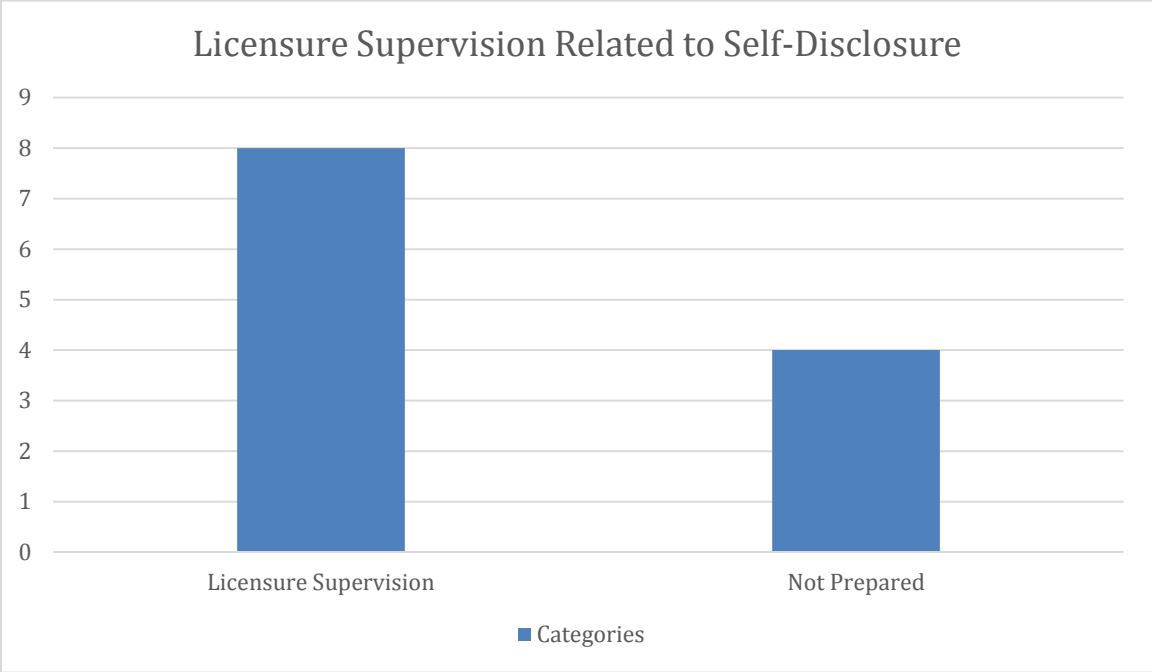

Figure 8. Response to having licensure supervision related to self-disclosure.

Summary

This study investigated the perceived preparation for engaging in SD as a novice LPC. The study's objective was to focus on the counselor's perception based on their experience. The findings indicate that LPCs perceived having been prepared to self-disclose by their lived experience, clinical practice, education and licensure supervision. Participants stated that they had learned to self-disclose mainly through clinical practice. However, there were two participants that perceived they have not been prepared to use SD. The next chapter provides an interpretation of the findings, limitations, recommendations, and implications.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

This purpose of this study was to research how novice LPCs perceive their preparedness to use SD. In this study, I considered non-verbal and verbal SD and explored the phenomenon through a qualitative method using the exploratory multiple-case study approach. Participants in this study understood the meaning of SD and use SD in-session with clients. Eight of the LPCs used a moderate amount of SD, while three indicated a minimal use of SD. Only one LPC stated they self-disclosed significantly in their sessions with clients.

The LPCs in this study identified life experience, clinical practice, education, and supervision as having prepared them to use SD. Six of the 12 LPCs indicated that education prepared them to use SD. Nine of the 12 participants identified their clinical practice during field training had prepared them to use SD. Eight of the 12 participants stated supervision during licensure was a factor in having been prepared to use SD. However, when focused on having learned to use SD, nine interviewees reported that clinical practice was the primary factor in having learned the skill.

Interpretation of the Findings

Much of the current research has indicated that LPCs are using SD (Audet, 2011; Berg, Antonsen, & Binder, 2016; Ruddle & Dilks, 2015; Ziv-Beiman, 2013). I found that all 12 participants reported using SD to some extent. One participant reported using a significant amount of SD throughout the sessions. Three interviewees stated they used SD in moderation. The majority of the LPCs (eight) said they minimally engaged in SD.

This finding is concurrent with the findings yielding by Audet (2011), Berg et al. (2016), and Ziv-Beiman (2013).

The extent of SD use varied among the LPCs. However, the use of SD was prevalent among all the interviewees in this study. Participants reported using both verbal and non-verbal SD. The participants were able to define verbal SD according to the definitions provided in recently published studies. SD is defined as a therapeutic intervention in which the mental health professional discloses something personal about him or herself to the client (Berg et al., 2016). The LPCs commented that verbal SD was a revelation about themselves to the client.

The participants were able to differentiate between verbal and non-verbal SD. For example, one participant stated that verbal SD was "something that I say to the client about me." Respondents explained that non-verbal SD is body language. The definition of non-verbal SD is inclusive of décor, attire, jewelry, and body language (Berg et al., 2016). Based on this study, the participants could not define non-verbal SD as defined in the current literature. Their inability to expand the definition of non-verbal SD implies that this study's participants cannot accurately define non-verbal SD.

In this study, I sought to explore how novice LPCs perceive their preparedness to use SD. The interviewees reported that they perceived themselves as having learned to use SD through life experience, clinical practice, education, and supervision. Half of the participants reported that their education prepared them to use SD. Of the 12 interviewees, only six could recall having educational training that provided them with preparation to use SD. Three participants reported that SD was brought up in every

course, but that SD was not a specific area of review. One participant mentioned that SD was discussed in an ethics class. This finding aligns with Knight's (2014) conclusion that the classroom is a difficult environment to prepare counselors in the skill of SD. Half of the participants of this study stated that teachers did not talk about SD. Knight (2014) found that many educators may be unsure of what and how to teach students about SD. The finding of this study aligns with Knight's (2014) conclusion.

Nine LPCs in this study reported that field training prepared them to use SD. The participants reported that having the opportunity to practice SD gave them the ability to learn how to use SD. Knight (2014) determined that field training was the optimum opportunity to practice SD. These nine participants also found that field training provided them with the best place to make mistakes, learn through trial and error, and gain experience in using SD.

Also, eight of the participants reported that they perceived having learned SD through supervision while securing their licensure. This finding is contrary to those of Spence et al. (2014) who concluded that supervisees would not be inclined to talk with supervisors about SD. Spence et al. (2014) found that supervisees would fear that acknowledged use of SD would appear to be a weakness or concern with not maintaining boundaries. In this study, 75% of the participants said they did talk about SD with their supervisors and they perceived it as helping them learn to use SD. However, only four of the nine interviewees had supervisors who brought the topic up first and often. Five of the nine participants had to bring the topic up with their supervisors for it to be reviewed. Based on these results for these participants, I determined that supervision is a setting to

learn about the use of SD even though supervisors of these LPCs did not prompt the conversation.

Therefore, I found that most LPCs perceived having learned SD through clinical practice. The therapists in Berget et al.'s (2016) study concluded that they learned SD through errors made in their careers. The LPCs of this study also identified having perceived learning SD through trial-and-error, taking a chance and making mistakes. During the interview, participants were specifically asked to recall how they perceived learning to use SD through educational training, field experience, and supervision. Participants reported whether they perceived themselves as having been prepared by those mediums. However, when asked how they perceived themselves to have been prepared to use SD, they responded saying clinical practice prepared them. Participants did give some recognition to having learned SD through their education, field training, and supervision when prompted to consider those aspects. When I asked participants to explain how they learned to use SD, the majority stated that clinical experience and trying the skill were central.

Limitations

Qualitative research findings are hard to generalize to broader populations (Maxwell, 2005; Yin, 2014). My aim in this study was not to generalize the findings beyond the participants. I used a convenience and purposeful sample that reflected just the perceptions of those interviewed. I did not interview any LPCs outside the states of Delaware, New Jersey, and Pennsylvania, and there was a disproportionate number of participants from Pennsylvania. Eight Pennsylvanian LPCs completed the interview,

while there were just two from Delaware and two from New Jersey. Of the 12 participants, 11 were female, and only one was male.

The study was intentionally limited to novice LPCs. As such, I only contacted counselors who had less than 5 years of experience practicing in the field of mental health counseling. Ten of the 12 participants reported working with a variety of clients who presented with anxiety, job dissatisfaction, marital conflict, sibling conflict, depression, severe mental health illnesses, and relational issues. The other two interviewees stated they worked in drug and alcohol facilities. There was thus a lack of representation across the many domains of mental health counseling.

All the data I collected was based on the recollection of the respondents. Therefore, validity is a concern. The interviewees were asked to recall their preparedness to use SD. It is beyond my capacity as a researcher to know with absolute certainty if the remembrances, as provided by the participants, were accurate. My focus was on LPCs' perceptions; therefore, the data given could be assumed as fact as perceived by the LPC.

Recommendations

Counselors' perceived preparedness to use SD is worth future research. This study showed some areas that need more attention. The first area is the disproportionate number of male to female respondents. The perceptions of males should be more thoroughly explored to examine gender differences in preparation and use of SD. Since only one male responded to my invitation to participate, male novice LPCs are significantly underrepresented.

A second area to further explore is the perceptions of counselors from a larger population. LPCs in this study graduated from both brick-and-mortar schools and online institutions. The sample is representative of 12 different universities. However, this sample is very small in consideration of the total number of universities in the United States. LPCs from other states and demographics may offer further insights regarding the phenomenon. Also, it is worth exploring perceptions of counselors who specialize in various forms of mental health counseling such as trauma therapies, grief counseling, art therapy, and family counseling.

A third for further exploration is the perceptions of counselors who have more years practicing as LPCs. Curriculum programs are developed and modified over time. Recent graduates have a different educational experience than counselors who graduated 10 or more years previously. Therefore, it is worth exploring how LPCs perceived their preparation to use a skill that was not always viewed as appropriate to use in-session. It may be useful to explore how experienced counselors perceive their preparedness to use SD as scholarly and clinical opinions regarding SD have changed over time.

Implications

The use of SD has been considered largely arguable as one of the most controversial therapeutic interventions (Berg et al., 2016; Ziv-Beiman, 2013). A review of the research indicated that the controversy over SD use is supported as it has vast potential for positive and negative impacts on the client. However, it is almost impossible not to self-disclose to clients. The presence of a wedding ring, counselor gender and dress style are all immediate non-verbal SDs that occur without intent. Even counselors who refrain from verbal SD will self-disclose. Therefore, it is of importance to understand how counselors view that they are well-prepared to use the skill.

Participants of this study suggested the understanding to use SD come from increased mindfulness. One participant stated to use SD you must "know yourself, take your own healing journey." Another participant stated, "If it is something that I have already processed, then I am comfortable talking about it." The participants of this study identified that self-healing is important to be able to use SD. There are implications that counselors seek personal counseling to go through their healing journey in preparation to use SD.

Participants that were in private practice reiterated that they have engaged in debriefing with colleagues and peer counselors about their use of SD. The LPCs of this study that worked in private practice mentioned they like when there were other LPCs in the building to talk to about issues that arose from session. There is an implication that ongoing peer debriefing could be a valuable resource.

LPCs that worked for an organization mentioned having mandatory supervision. The supervision was in a group setting with peers and a supervisor. Participant five stated that there are regulatory group supervisions: “well we have weekly group supervision. It is just dialogue with peers and we talk about use of SD and who to say what to and who not to say things to.” Conversation about use of SD is on-going as it is complex. Participant two explained, “I just feel like self-disclosure is not as cut and dry and black and white as people would like it to be.” There is an implication that due to the intricacies of SD, it may be of benefit to engage in ongoing supervision with an experienced LPC or group of LPCs.

Social Change Implications

The purpose of this study was to have a rich understanding of how novice LPC perceived themselves as being prepared to use the therapeutic skill of SD. The importance of this exploration was to further what is already known in the literature about LPCs use of SD. The research supports that LPCs use SD, have become prepared to use SD, discuss SD and that SD can still be detrimental to clients. The underlining reason for conducting this study is to generate thought provocation on how to decrease harm to clients when using SD. SD aids in the creation of a therapeutic relationship and manipulates a client to feel comfortable enough to share more of themselves in-session. However, because SD is so powerful, the user must be well-prepared as to avoid harm.

This study explored the perceptions of novice LPCs who are newer to the field having up to five years of experience. This study provides a better understanding of novice LPCs experiences and perceptions so that the field can better realize how to

prepare LPCs in using SD. In having identified themes, LPCs stated life experience, clinical practice, education, and supervision had prepared them to use SD. However, there was a clear distinction in which the participants reported learning to use SD was from practice, trial and error. It is essential that we do not use our clients as practice without the capability of remediation. Therefore, this study offers the opportunity to understand this phenomenon with implications of how to proceed with further research as to better prepare LPCs with the skill of SD.

Conclusion

The findings of this study are that novice LPC are using the skill of SD in-session with their clients. The extent of SD varies among the participants of this study from minimal to significant use. The interviewees could identify perceptions of being prepared to use SD through their education, field training, and during supervision while acquiring their license to practice. The participants reported learning through these methods above when prompted to discuss their learning of SD through education, field training, and supervision. However, when participants were asked to identify how they learned to SD without given a prompt to how they best learned to SD, they responded that they learned to use SD by practice and life experience.

The novice LPCS reported they perceived they best learned to self-disclose by practicing the skill with clients in-session. Interviewees reported that by self-disclosing with a client they could “try out” what it felt like to disclose personal information to a client. The participants explained that sometimes they would self-disclose and realize they shared too much. Other times the LPC would self-disclose and recognize that it

helped to further the client's process of counseling. The participants of this study reported that having the opportunity to use SD in-session gave them the experience to learn "what worked and what didn't" when self-disclosing.

Attachment theory assists with understanding the trial and error method of SD. Bowlby (1988) stated that when a person makes the correct use of SD their internal working model is reinforced. The more correct guesses a person makes, the more efficient their internal working model (Bowlby, 1988). The LPCs in this study echoed Bowlby's (1988) finding that the more correct uses of SD, the more they felt prepared to continue using SD appropriately.

Inappropriate use of SD can be detrimental to the client. LPCs can significantly harm clients if they do not appropriately apply the skill of SD. This study found that LPCs are using SD and perceive themselves as prepared to use SD through practice. There are implications that counselors receive enhanced support during their practice of self-disclosing given the possible negative impact on clients. Novice LPCs may benefit from a revised curriculum that addresses practicing SD in a protected environment. LPCs may benefit from ongoing regulated supervision. Two interviewees suggested novice LPCs enroll in counseling for them to take the healing journey before practicing independently. Future research can address how to prepare novice LPCs to use the skill of SD based on this study's findings.

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Appendix A: Invitation to Participate

Research study: LPCs and Self-Disclosure Use

Good day, my name is Nicole Pfaff and this email is an invitation to consider participating in a study I am conducting as part of my doctoral degree in the Department of Human Services at Walden University under the supervision of Lillian Chenoweth, Ph.D. Information about this project and the expected participant involvement, should you decide to take part, is below:

Background Information:
The current trend in the counseling field is for licensed professional counselors to engage in self-disclosure with a client. Many LPCs are using self-disclosure as an integrative approach to therapy. Self-disclosure is also used to strengthen the therapeutic relationship and facilitate growth with the client. An LPC's use of self-disclosure can enhance the therapeutic relationship and build a therapeutic alliance. This purpose of this study is to engage in a conversation that explores how you as a novice licensed professional counselor perceive yourself as being prepared to utilize the skill of self-disclosure.

Participation Criteria:
I would like to include you in my study as you have been identified as a clinical mental health counseling graduate from a CACREP institution named [NAME OF UNIVERSITY]. There are specific requirements to be a part of this study. They include:

1. Completed a Master's degree in clinical mental health counseling from a CACREP accredited college
2. Professional experience practicing as a LPC for at least 1 year, but not more than 5 years
3. Registered with your respective state of professional practice as a LPC

Procedures:
If you agree to be in this study, you will be asked to:

- **Notify Nicole by email (nicole.pfaff@waldenu.edu) or phone (xxx-xxx-xxxx) that you are willing to be involved in this study**
- Meet face-to-face with Nicole for an interview that will be audio recorded
- Sign the informed consent form that would allow you to participate in the study
- Spend approximately 30 minutes on one occasion answering questions and talking about your professional experiences with self-disclosure
- Verify that I have captured your exact words by reviewing a typed manuscript of our interview

Vulnerable Population Disclosure:
Due to the limited potential risks of making travel arrangements to meet for a face-to-face interview, respond to follow-up questions, and consent to necessary paperwork to participate in this study, the intent of this researcher is to not include those individuals that identify as being younger than 18 years old, elderly, pregnant or incarcerated.

I would very much look forward to hearing from you within two weeks of the delivery of this email, but no later than [DATE]. I greatly appreciate your time and consideration thus far and await further conversation.

Sincerely,
Nicole Pfaff, MS, LPC
Ph.D. candidate, Human Services, Walden University

Appendix B: Interview Questions

Thank you for being willing to participate in this research study. The information that you provide today is important to the work of licensed professional counselors because it helps professionals know more about how LPCs perceive themselves as being prepared to engage in using self-disclosure with clients. LPCs use many therapeutic techniques in-session with clients, but this study will only focus on self-disclosure. None of the information that you share will be shared in such a way that you would be identified.

If you have any reservations about being a part of this study, we can discuss that now or you may opt-out of participating. You can also opt-out of participating at any point throughout the interview. Please know that you are under no obligation to complete this study. Any information that you offer will only be used for the purposes of this research study. If you consent to proceed I would like to turn on the recorder and begin the interview.

1. Please describe your professional credentials and clientele population.
2. Tell me about your use of self-disclosure.
3. Please describe your understanding of the use of verbal self-disclosure.
4. Please describe your understanding of the use of non-verbal self-disclosure.
5. How did or do you determine when to use self-disclosure?
6. How did or do you determine when not to use self-disclosure?
7. How do you perceive that you were prepared to use the skill of verbal self-disclosure with clients?

8. How do you perceive that you were prepared to use the skill of non-verbal self-disclosure with clients?
9. Please talk about how you have learned to self-disclose with clients.
10. Please talk about any educational training that you have had relating to self-disclosure.
11. Please talk about any field training (i.e. practicum, internship) related to the use of self-disclosure.
12. Please talk about any supervisory experience related to the use of self-disclosure.
13. Please talk about how you were prepared to use self-disclosure.
14. What have you discussed about the use of self-disclosure with a peer, supervisor or supervisee? What was the context of that conversation?
15. What would you tell other counselors about becoming prepared to use self-disclosure?